Daniel Nibouar
Interim Director

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

T 503-655-8378

clackamas.us

DATE: November 18, 2021

TO: Gary Schmidt, County Administrator

FROM: Daniel Nibouar, Interim Disaster Management Director

SUBJ: Current Emergency Declaration Recommendations

The purpose of this memorandum is to provide you and the Board of County Commissioners (BCC) with information and recommendations about the current county emergency declarations for COVID-19 recovery and debris due to the 2020 wildfires.

COVID-19 Recovery

The current COVID-19 emergency declaration is focused on recovery. The recovery from COVID-19 will take a long time, but it no longer requires an emergency declaration to prioritize. There is also no longer a need for the other emergency authorities granted in the declaration. Disaster Management and Public Health have coordinated with Social Services and Business & Community Services to make sure the authorities are no longer needed.

Wildfire Debris Declaration

The county is still actively working with the Oregon Department of Transportation (ODOT) to clean up debris from the 2020 Wildfires. ODOT has completed the private property debris removal in the county, but is just starting on removing hazardous trees from the right-of-way. The emergency declaration allows the county to maintain flexibility in support ODOT's operations. The county is currently utilizing the debris monitoring contract to have a liaison to coordinate between property owners and ODOT to ensure the debris removal meets the property owner's needs. The extension of the emergency declaration will also give the county the possibility of utilizing the county's debris removal contract, if ODOT is unable to perform the work.

Recommendation

COVID-19 Recovery emergency declaration: Allow the current declaration to end of its current period, December 31, 2021. If emergency authorities are needed again, Disaster Management and Public Health will make a recommendation for another declaration at that time.

Wildfire Debris emergency declaration: Extend the current declaration until March 15, 2022, the estimated date of ODOT's completion of removal of hazardous trees from the right-of-way. If ODOT completes earlier, Disaster Management will notify the board at that time.

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

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

MEMORANDUM

To: Board of County Commissioners

From: Dan Johnson, Director

Date: November 11, 2021

Re: Canby Ferry – Hours of Operation

The Department of Transportation and Development, through its Transportation Maintenance program currently staffs and operates the Canby Ferry crossing the Willamette River north of Canby. A number of years ago staff brought forward a discussion on the future of the ferry and possible alternatives, such as a toll bridge, for consideration by the public and the Board of Commissioners. At that time it was decided to retain the current ferry system but staff was tasked with continuing to assess other revenue and cost reduction options to reduce the reliance on road funds to provide this valued community service.

Currently the ferry is staffed by 3 ferry operators and 5 relief/backup operators. With a recent ferry operator vacancy management felt it was a good time to assess operations to see if there may be some efficiencies. That assessment illustrated a possible 25% increase in efficiency or reduction in the reliance on road fund revenue with a change in the ferry schedule.

Current ferry operating structure:

- The Canby Ferry is open 7 days a week 6:30am-7:00pm
- Employee Shift 1-Mon-Fri 6:00am-1:30pm—Saturday and Sunday off
- Employee Shift 2-Thurs-Fri 12:00pm-7:30pm and Sat-Mon 6:00am-1:30pm—Tuesday and Wednesday off
- Employee Shift 3-Sat-Wed 12:00pm-7:30pm—Thursday and Friday off

The current schedule provides for unneeded overlap and shortened hours of work on a daily basis.

If we were to retain the vacancy and alter schedules from a 5 day 8 hours a day to a 4 day 10 hour work schedule we could provide essentially the same level of service at a lower cost.

New operating structure (beginning January 1st, 2022):

- The Canby Ferry is open 7 days a week 9:30am-6:30pm (soft closure daily from 1:00pm-1:30pm to allow them to take their ½ hour paid lunch – required under the Collective Bargaining Contract)
- Employee Shift 1-Mon-Thurs 9:00am-7:00pm
- Employee Shift 2-Thurs-Sun 9:00am-7:00pm

This would have both operators working 10 hours to get paid for 10 hours (with a paid one-half (1/2) hour lunch break) and we would have double coverage on Thursday while covering all of our busiest hours (using a 5 year average). These hours of operation changes may result in a slight reduction in some revenue, unless the riders adapted to the new hours, but would potentially significantly increase our efficiency. If the need to remain open later than 7:00pm, because of an I-5 traffic accident or some other unforeseen reason, we will authorize overtime and accommodate that need still.

The most significant change is the start of business change from 6:30 am to 9:30 am. Data shows ridership is low at this time, approximately 15 vehicles a day during this time, resulting in an estimated revenue reduction of $75 a day. If you were to assume the ferry operated every day of the year, which it doesn't, the lost revenue would equate to $27,375. Assuming the loaded rate of the Ferry Operator position, the savings with not having to fill the vacant ferry operator position would equate to approximately $128,960 annually. Resulting in a net savings of $101,585 and an approximate 25% reduction of Road Fund subsidy.

Staff will advance a public information campaign immediately to ensure riders have adequate advanced notice of the proposed changes.

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

MEMORANDUM

To: Board of Commissioners

From: Rodney Cook, Director of Health Housing and Human Services (H3S)
Dan Johnson, Director of Transportation and Development (DTD)

Date: November 17, 2021

Re: Land Lease Renewal for the Veteran's Village

The Veterans Village is sited on a portion of a remnant property owned by the Clackamas County Development Agency at 16575 SE 115th Ave.

Clackamas County began operation of the Veterans Village as a pilot transitional shelter community program in October of 2018. This program was enacted in alignment with the County's strategic goal of ending veteran homelessness.

At the end of the two-year pilot period, on December 15th, 2020, the Board of County Commissioners unanimously approved a resolution to continue the current operations of the program, negotiating an extension of the lease with the Development Agency while exploring options for the County, through H3S, to purchase the property for the continuation of the Veteran's Village Program.

As H3S continues to assess options and opportunities for additional transitional services, staff would request the Board support a one year extension on the current lease with an option of an automatic one additional year extension to provide additional time to assess options at this facility and elsewhere throughout the County. Unfortunately the current lease expired on September 30, 2021 so time is of the essence to ensure no interruption of service to the current occupants.

Should the Board affirm this extension staff will advance drafting a revised lease agreement for formal Board approval at a future business meeting.

CLACKAMAS COUNTY

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

AGENDA

Wednesday November 24, 2021 - 10:00 AM
BOARD OF COUNTY COMMISSIONERS

Beginning Board Order No. 2021-81

CALL TO ORDER
- Roll Call
- Pledge of Allegiance

*****COVID-19 Updates**

I. PUBLIC HEARINGS *(The following items will be individually presented by County staff or other appropriate individuals. Persons appearing shall clearly identify themselves and the department or organization they represent. In addition, a synopsis of each item, together with a brief statement of the action being requested shall be made by those appearing on behalf of an agenda item.)*

a. Approval of a Board Order Accepting a Request to Transfer Jurisdiction from Clackamas County to the City of Molalla of a Portion of S. Ona Way (County Road #1303, DTD #52003) to the City

II. 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. Elected Officials

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

III. PUBLIC 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. Testimony is limited to three (3) minutes. Comments shall be respectful and courteous to all.)*

Please note, the ideas expressed during public communication do not necessarily reflect the ideas or beliefs of Clackamas County or the Board of County Commissioners.

IV. COUNTY ADMINISTRATOR UPDATE

V. COMMISSIONERS COMMUNICATION

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

Appointed Boards and Commissions (ABCs) Recommendation

The Developmental Disabilities (DD) Council, staffed by the Health, Housing, and Human Services Department (H3S), currently has between 7 and 18 openings on their commission due to term expirations. 18 members are allowed with 3 year terms.

Recruitment initially opened to the public on 8/25/2021 and closed on 9/30/2021. It reopened on 10/25/21 and will close on 11/30/21, due to open spaces to fill. Recruitment took place by press release, Facebook, Nextdoor, and the county website. Through this recruitment process, 11 applications (4 family/individuals and 7 providers) were received and 4 family/individuals were recommended to be appointed. This initial selection was only for family/individuals with ID/DD. The next interview round will be for providers. Interviews were conducted with all eligible applicants.

The initial recommendation is as follows:

Lisa Ledison	1	3 terms, ending 12/1/2024
Gabriele Graebert-Rodriguez	2	1 term, ending 12/1/2022
Neil Dixon	1	2 terms, ending 12/1/2023
Shasta Kearns-Moore	1	3 terms, ending 12/1/2024

The Board of County Commissioners could select other candidates or require further recruitment.

Please sign as appropriate indicating that a matrix and all applications are attached. The material has been reviewed by the appropriate signing authority, and the packet is ready for consideration by the BCC.

Liaison signature: Kim Cota Date: 11/10/21

Division approval: Brenda Durbin Date: 11/17/21

Department approval: [signature] Date: 11/17/21

ABC Matrix						
Clackamas County 2021 - *Developmental Disabilites Council*					*Todays Date: 11/17/2021*	
First Name	**Last Name**	**If this Position is currently a Vacancy (Member resigning, Member being reppointed)**	**Occupation/Background**	**Term Overview (1st, 2nd,etc)**	**Appointment Date (Month/Day/Year)**	**Term expires (Month/Day/Year**
Active Roster						
First Name	**Last Name**	**If this Position is currently a Vacancy (Recommending applicant as new member)**	**Occupation/Background**	**Term Overview (1st, 2nd,etc)**	**Determined by the BCC (approval date)**	**Term Expires (Month/Day/Year)**
New Members Recommended						
Lisa	**Ledison**			**1**		**12/1/2024**
Gabriele	**Graebert-Rodriguez**			**2**		**12/1/2022**
Neil	**Dixon**			**1**		**12/1/2023**
Shasta	**Kearns-Moore**			**1**		**12/1/2024**

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Housing Authority Board of Commissioners
Clackamas County

Members of the Board:

Approval to execute a contract between the Housing Authority of Clackamas County (HACC) and El Programa Hispano Catòlico to provide Supportive Housing Case Management and Housing Navigation and Placement. Not to Exceed $462,917.00
No County General Funds Involved

Purpose/Outcomes	Approval to execute the contract between HACC and El Programa Hispano Catòlico to provide housing navigation and placement as well as supportive housing case management services for the Supportive Housing Services Program
Dollar Amount and Fiscal Impact	Total value for the contract over the contract terms is $462,917.00
Funding Source	Supportive Housing Services Program funding as identified and approved by the Board of County Commissioners – No County General Funds are involved
Duration	Upon signature through October 31, 2022
Previous Board Action	N/A
Strategic Plan Alignment	1. Sustainable and affordable housing 2. Ensure safe, healthy and secure communities
Counsel Review	11/08/21; Andrew Naylor
Contact Person	Vahid Brown, Human Services Manager, 971-334-9870
Procurement Review	This procurement process was conducted by HACC staff in partnership and approval from County Finance and the County Procurement office. The RFP was conducted with compliance of County and Local Contract Review Board rules and leadership oversight from Procurement.
Contract No.	Contract No. 10376

BACKGROUND:

The Housing Authority of Clackamas County (HACC), a division of the Health, Housing and Human Services Department (H3S) of Clackamas County, requests approval to execute a contract with El Programa Hispano Catòlico to provide supportive housing case management services and housing navigation and placement services for the Supportive Housing Services Program (SHS Program). The SHS Program is focused on providing permanent supportive housing and supportive services to vulnerable individuals in Clackamas County currently experiencing or at risk of experiencing homelessness, many of whom have a disability.

On August 5th, HACC issued a Request For Proposals (RFP) #06-2021 for supportive housing case management and housing navigation and placement services for the initial roll out of the SHS Program. This procurement process was conducted by HACC staff in partnership and approval from County Finance and the County Procurement office. The RFP was conducted with compliance of County and Local Contract Review Board rules and leadership oversight from Procurement. HACC received eleven (11) applications which were evaluated by members of the Continuum of Care Steering Committee (CoCSC), as the inclusive decision making body for the SHS Program as outlined in the Clackamas

County Local Implementation Plan (LIP). The five highest scoring applicants were notified of their award on September 2nd. El Programa Hispano Catòlico was awarded to provide both supportive housing case management and housing navigation and placement services.

El Programa Hispano Catòlico is a culturally specific service provider which has assisted Latinx and BIPOC Oregonians for nearly 40 years. Each year El Programa Hispano Catòlico serves over 22,000 Latinx and BIPOC Oregonians through a plethora of stabilizing and supportive programs. Through this contract they will provide housing navigation and placement for at least 20 households and supportive housing case management services to at least 50 households.

El Programa Hispano Catòlico will be providing housing navigation and placement services to assist households in locating and securing permanent housing by assisting them in overcoming any barriers they may be experiencing. They will link households to rent assistance vouchers programs including the Regional Long-term Rent Assistance Program (RLRA) and will also link them to ongoing Supportive Housing Case Management as needed to stay stably housed.

El Programa Hispano Catòlico will be providing Supportive Housing Case Management to households needing additional wrap-around services in permanent placements. Supportive housing case management is often the missing piece that when added to rent assistance programs can lead to greater housing success.

The initial population served by this contract will be those transitioning from time-limited or temporary emergency housing to more permanent housing solutions. The contract also allows for additional households to be served as capacity and funding allows. This contract will secure services for one year with options to extend and expand to add new households for up to three additional years.

Together, providers awarded through this first successful RFP will be able to assist approximately 100 households with housing navigation and placement services and approximately 200 households with supportive housing case management services and begin the roll out of the SHS Program.

RECOMMENDATION:
Staff respectfully recommends that the Housing Authority Board of Clackamas County approve the contract between El Programa Hispano Catòlico and HACC to provide supportive housing case management and housing navigation and placement services for the SHS Program. Staff also recommends the Board authorize Commissioner Tootie Smith, Chair, to sign on behalf of the Housing Authority Board.

Respectfully submitted,

Mary Rumbaugh

Rodney A. Cook, Director
Health, Housing and Human Services

HOUSING AUTHORITY OF CLACKAMAS COUNTY
PERSONAL SERVICES CONTRACT
Contract # 10376

This Personal Service Contract (this "Contract") is entered into between the Housing Authority of Clackamas County ("HACC") and El Programa Hispano Catolico ("Contractor") collectively referred to as the "Parties" and each a "Party." HACC is a Public Corporation, established under the Federal Housing Act of 1937 and the provisions of Chapter 456 of the Oregon Revised Statutes.

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 October 31, 2022.

2. **Scope of Work.** Contractor shall provide the following personal services: provide housing navigation and placement as well as supportive housing case management services ("Work"), further described in **Exhibit A.**

3. **Consideration.** HACC agrees to pay Contractor, from available and authorized funds, a sum not to exceed Four Hundred Sixty Two Thousand Nine Hundred Seventeen dollars **($462,917),** for accomplishing the Work required by this Contract. Consideration rates are on a fixed budget basis in accordance with the 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 B.

   Contractor understands and agrees that HACC's obligation to pay Contractor for performing the Work under this Contract is expressly contingent upon HACC receiving sufficient funds, as determined by HACC in its sole administrative discretion, from the Metro Regional Government ("Metro") under the supportive housing services program tax, approved as ballot measure 26-210.

4. Advances of Funds. Contractor may request and be paid in advance up $115,729.25 to perform the Work under this Contract. Advance payments to Contractor must be limited to the minimum amounts needed and be timed to be in accordance with the actual, immediate cash requirements of Contractor in performing Work under this Contract.

5. **Invoices and Payments.** Unless otherwise specified, Contractor shall submit monthly invoices for Work performed. Invoices shall describe all Work performed with particularity, by whom it was performed, and shall itemize and explain all expenses for which reimbursement is claimed. The invoices shall include the total amount billed to date by Contractor prior to the current invoice. If Contractor fails to present invoices in proper form within sixty (60) calendar days after the end of the month in which the services were rendered, Contractor waives any rights to present such invoice thereafter and to receive payment therefor. Payments shall be made in accordance with ORS 293.462 to Contractor following HACC's review and approval of invoices submitted by Contractor. Contractor shall not submit invoices for, and HACC 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. See Exhibit C.

   Invoices shall reference the above Contract Number and be submitted to: Housing Authority of Clackamas County, HACCAP@clackamas.us

6. **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 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.

7. **Contract Documents.** This Contract consists of the following documents, which are listed in descending order of precedence and are attached and incorporated by reference, this Contract, Exhibit A, Exhibit B, Exhibit C, and Exhibit D.

8. **Contractor and HACC Contacts.**

Contractor	HACC
EPHC's Executive Director: Edith Quiroz Phone: (503)489-6809 Email: equiroz@elprograma.org	Administrator: Vahid Brown Phone: (971) 334-9870 Email: vbrown@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. HACC 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 HACC 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 HACC without regard to principles of conflicts of law. Any claim, action, or suit between HACC 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 HACC 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 HACC, Clackamas County, and their officers, elected officials, agents and employees ("Indemnified Parties") 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 the Indemnified Parties, nor purport to act as legal representative of the Indemnified Parties, without first receiving from the Clackamas County Counsel's Office authority to act as legal counsel for the Indemnified Parties, nor shall Contractor settle any claim on behalf of the Indemnified Parties without the approval of the Clackamas County Counsel's Office. The Indemnified Parties may, at their election and expense, assume provide housing navigation and placement as well as supportive housing case management services their own defense and settlement.

8. **INDEPENDENT CONTRACTOR STATUS.** The service(s) to be rendered under this Contract are those of an independent contractor. Although HACC 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, HACC 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 HACC 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 HACC 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. The insurance requirement outlined below do not in any way limit the amount of scope of liability of Contractor under this Contract. Contractor shall provide proof of said insurance and name HACC and Clackamas County as an additional insured on all required liability policies. Proof of insurance and notice of any material change should be submitted to the following address: Housing Authority of Clackamas County, PO Box 1510, Oregon City, OR 97045 or HACCSHS@clackamas.us.

Required - Workers Compensation: Contractor shall comply with the statutory workers' compensation requirements in ORS 656.017, unless exempt under ORS 656.027 or 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 claim, 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 accident for Bodily Injury and Property Damage.
☒ Required – Sexual Abuse and Molestation: combined single limit, or the equivalent, of not less than $1,000,000 per accident for Bodily Injury and Property Damage.

The policy(s) shall be primary insurance as respects to HACC. Any insurance or self-insurance maintained by HACC shall be excess and shall not contribute to it. Any obligation that HACC 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 20 neither party shall be liable for (i) any indirect, incidental, consequential or special damages under this Contract or (ii) any damages of any sort arising solely from the termination of this Contact in accordance with its terms.

11. **NOTICES.** Except as otherwise provided in this Contract, any required notices between the parties shall be given in writing by personal delivery, email, or mailing the same, to the Contract Administrators identified in Article 1, Section 6. If notice is sent to HACC, a copy shall also be sent to: Housing Authority of Clackamas County, PO Box 1510, Oregon City, OR 97045, or HACCSHS@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 HACC'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 HACC. HACC and Contractor intend that such Work Product be deemed "work made for hire" of which HACC shall be deemed the author. If for any reason the Work Product is not deemed "work made for hire," Contractor hereby irrevocably assigns to HACC 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 HACC may reasonably request in order to fully vest such rights in HACC. 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, HACC shall have no rights in any pre-existing Contractor intellectual property provided to HACC by Contractor in the performance of this Contract except to copy, use and re-use any such Contractor intellectual property for HACC use only.

13. **REPRESENTATIONS AND WARRANTIES.** Contractor represents and warrants to HACC that (A) Contractor has the power and authority to enter into and perform this Contract; (B) this Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms; (C) Contractor shall at all times during the term of this Contract, be qualified, professionally competent, and duly licensed to perform the Work; (D) Contractor is an independent contractor as defined in ORS 670.600; and (E) the Work under this Contract shall be performed in a good and workmanlike manner and in accordance with the highest professional standards. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

14. **SURVIVAL.** All rights and obligations shall cease upon termination or expiration of this Contract, except for the rights and obligations set forth in Article II, Sections 1, 6, 7, 10, 12, 13, 14, 15, 17, 20, 21, 25, 27, 28, and 31 and all other rights and obligations which by their context are intended to survive. However, such expiration shall not extinguish or prejudice HACC'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 HACC, which shall be granted or denied in HACC's sole discretion. In addition to any provisions HACC 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. HACC'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 HACC to terminate this Contract, to pursue and recover any and all damages that arise from the breach and the termination of this Contract, and to pursue any or all of the remedies available under this Contract or applicable law.

19. **TERMINATIONS.** This Contract may be terminated for the following reasons: (A) by mutual agreement of the parties or by HACC (i) for convenience upon thirty (30) days written notice to Contractor, or (ii) at any time HACC fails to receive funding, appropriations, or other expenditure authority as solely determined by HACC; or (B) if Contractor breaches any Contract provision or is declared insolvent, HACC may terminate after thirty (30) days written notice with an opportunity to cure.

    Upon receipt of written notice of termination from HACC, Contractor shall immediately stop performance of the Work. Upon termination of this Contract, Contractor shall deliver to HACC all documents, Work Product, information, works-in-progress and other property that are or would be deliverables had the Contract Work been completed. Upon HACC's request, Contractor shall surrender to anyone HACC designates, all documents, research, objects or other tangible things needed to complete the Work.

20. **REMEDIES.** If terminated by HACC due to a breach by the Contractor, then HACC 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 pro rata permitted annual costs incurred as of the date of the notice of termination, less any amounts previously paid to Contractor by

HACC and any setoff to which HACC is entitled. As used herein, "permitted annual costs" means those costs identified in the budget set forth in Exhibit B, Personal Service Contract Budget, and incurred in accordance with this Contract.

21. **NO THIRD PARTY BENEFICIARIES.** HACC 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 HACC nor Contractor shall be held responsible for delay or default caused by events outside HACC 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 HACC to enforce any provision of this Contract shall not constitute a waiver by HACC 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 HACC on account of any labor or material furnished.
    d. Pay the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.
    e. As applicable, the Contractor shall pay employees for work in accordance with ORS 279B.235, which is incorporated herein by this reference. The Contractor shall comply with the prohibitions set forth in ORS 652.220, compliance of which is a material element of this Contract, and failure to comply is a breach entitling HACC to terminate this Contract for cause.
    f. If the Work involves lawn and landscape maintenance, Contractor shall salvage, recycle, compost, or mulch yard waste material at an approved site, if feasible and cost effective.

27. **NO ATTORNEY FEES**. In the event any arbitration, action or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Contract, each party shall be responsible for its own attorneys' fees and expenses.

28. **CONFIDENTIALITY.** Contractor acknowledges that it and its employees and agents may, in the course of performing their obligations under this Contract, be exposed to or acquire

information that HACC desires or is required to maintain as confidential. Any and all information of any form obtained by Contractor or its employees or agents in the performance of this Contract, including but not limited to Personal Information (as "Personal Information" is defined in ORS 646A.602(11), shall be deemed to be confidential information of HACC ("Confidential Information"). Any reports or other documents or items (including software) which result from the use of the Confidential Information by Contractor shall be treated with respect to confidentiality in the same manner as the Confidential Information.

Contractor agrees to hold Confidential Information in strict confidence, using at least the same degree of care that Contractor uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give or disclose Confidential Information to third parties or use Confidential Information for any purposes whatsoever (other than in the performance of this Contract), and to advise each of its employees and agents of their obligations to keep Confidential Information confidential.

Contractor agrees that, except as directed by HACC, Contractor will not at any time during or after the term of this Contract, disclose, directly or indirectly, any Confidential Information to any person, and that upon termination or expiration of this Contract or HACC's request, Contractor will turn over to HACC all documents, papers, records and other materials in Contractor's possession which embody Confidential Information. Contractor acknowledges that breach of this Contract, including disclosure of any Confidential Information, or disclosure of other information that, at law or in good conscience or equity, ought to remain confidential, will give rise to irreparable injury to HACC that cannot adequately be compensated in damages. Accordingly, HACC may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies that may be available. Contractor acknowledges and agrees that the covenants contained herein are necessary for the protection of the legitimate business interests of HACC and are reasonable in scope and content.

Contractor agrees to comply with all reasonable requests by HACC to ensure the confidentiality and nondisclosure of the Confidential Information, including if requested and without limitation: (a) obtaining nondisclosure agreements, in a form approved by HACC, from each of Contractor's employees and agents who are performing services, and providing copies of such agreements to HACC; and (b) performing criminal background checks on each of Contractor's employees and agents who are performing services, and providing a copy of the results to HACC.

Contractor shall report, either orally or in writing, to HACC any use or disclosure of Confidential Information not authorized by this Contract or in writing by HACC, including any reasonable belief that an unauthorized individual has accessed Confidential Information. Contractor shall make the report to HACC immediately upon discovery of the unauthorized disclosure, but in no event more than two (2) business days after Contractor reasonably believes there has been such unauthorized use or disclosure. Contractor's report shall identify: (i) the nature of the unauthorized use or disclosure, (ii) the Confidential Information used or disclosed, (iii) who made the unauthorized use or received the unauthorized disclosure, (iv) what Contractor has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure, and (v) what corrective action Contractor has taken or shall take to prevent future similar unauthorized use or disclosure. Contractor shall provide such other information, including a written report, as reasonably requested by HACC.

Notwithstanding any other provision in this Contract, Contractor will be responsible for all damages, fines and corrective action (including credit monitoring services) arising from disclosure of such Confidential Information caused by a breach of its data security or the confidentiality provisions hereunder.

The provisions in this Section shall operate in addition to, and not as limitation of, the confidentiality and similar requirements set forth in the rest of the Contract, as it may otherwise be amended. Contractor's obligations under this Contract shall survive the expiration or termination of the Contract, as amended, and shall be perpetual.

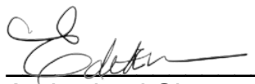
29. **CRIMINAL BACKGROUND CHECK REQUIREMENTS.** Contractor shall be required to have criminal background checks (and in certain instances fingerprint background checks) performed on all employees, agents, or subcontractors that perform services under this Contract. Only those employees, agents, or subcontractors that have met the acceptability standards of HACC may perform services under this Contract or be given access to Personal Information, Confidential Information or access to HACC facilities.

30. **COOPERATIVE CONTRACTING.** Pursuant to ORS 279A.200 to 279A.225, other public agencies may use this Contract resulting from a competitive procurement process unless the Contractor expressly noted in their proposal/quote that the prices and services are available to HACC only. The condition of such use by other agencies is that any such agency must make and pursue contact, purchase order, delivery arrangements, and all contractual remedies directly with Contractor; HACC accepts no responsibility for performance by either the Contractor or such other agency using this Contract. With such condition, HACC consents to such use by any other public agency.

31. **MERGER.** THIS CONTRACT CONSTITUTES THE ENTIRE AGREEMENT BETWEEN THE PARTIES WITH RESPECT TO THE SUBJECT MATTER REFERENCED THEREIN. THERE ARE NO UNDERSTANDINGS, AGREEMENTS, OR REPRESENTATIONS, ORAL OR WRITTEN, NOT SPECIFIED HEREIN REGARDING THIS CONTRACT. NO AMENDMENT, CONSENT, OR WAIVER OF TERMS OF THIS CONTRACT SHALL BIND EITHER PARTY UNLESS IN WRITING AND SIGNED BY ALL PARTIES. ANY SUCH AMENDMENT, CONSENT, OR WAIVER SHALL BE EFFECTIVE ONLY IN THE SPECIFIC INSTANCE AND FOR THE SPECIFIC PURPOSE GIVEN. CONTRACTOR, BY THE SIGNATURE HERETO OF ITS AUTHORIZED REPRESENTATIVE, IS AN INDEPENDENT CONTRACTOR, ACKNOWLEDGES HAVING READ AND UNDERSTOOD THIS CONTRACT, AND CONTRACTOR AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

By their signatures below, the parties to this Contract agree to the terms, conditions, and content expressed herein.

El Programa Hispano Catolico



11/03/2021

Authorized Signature Date

Edith Quiroz, Executive Director

Name / Title (Printed)

1077386-92

Oregon Business Registry #

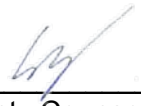
501(C)3

Entity Type / State of Formation

Housing Authority of Clackamas County

Tootie Smith Date

Approved as to Form



11/08/2021

County Counsel Date

SHS PROGRAM GUIDING PRINCIPLES AND EXPECTATIONS

I. Equity:

The Supportive Housing Services program promotes racial and ethnic justice and seeks to end disparities in housing access. HACC recognizes that culturally responsive and culturally specific services can eliminate structural barriers and provide a sense of safety and belonging, which will lead to better outcomes. HACC recognizes that advancing equity also includes having cultural competencies to provide services to other historically marginalized communities such as LGBTQ2SIA+, youth, people with disabilities, and immigrants and refugees. To further equity goals, Contractor must develop/implement the following:

- A plan to ensure culturally responsive service delivery that is respectful of all participants.
- A plan assuring access to services for people who do not speak the primary language of the service provider.
- A process to work with the HACC SHS team to continuously monitor the demographics of those accessing services using the HMIS (or an HMIS comparable database for domestic violence service providers).
- A quality improvement plan, informed by quantitative and qualitative data analysis, to address evidence of differential access, based on race, ethnicity, disability, gender identity, sexual orientation or other protected class status.
- Ensure that staff and volunteers have knowledge and experience to participate in the effort to increase equity and decrease housing disparities.
- Ensure that staff and volunteers have access to equity and inclusion training on an on-going basis.

Outcomes:

The SHS program is intended to end chronic homelessness in Clackamas County. In addition, HACC aims to make homelessness rare, short, and not reoccurring for all who live in Clackamas County. Programs must work in coordination to ensure housing options are safe, stable, and provide housing choice to meet the needs of each individual. The work of ending racial disparities in housing and ending homelessness is one and the same.

In addition to ending homelessness, Metro-wide outcome goals of the SHS program include:

- Advance housing equity by providing access to services and housing to Black, Indigenous and people of color at higher rates than their representation among those experiencing homelessness.
- House individuals and families, and support housing retention, at greater rates than those newly experiencing homelessness, to reduce the overall population of people experiencing homelessness.
- Reduce the average length of time anyone in Clackamas County experiences homelessness until people are offered housing options immediately upon becoming homeless.
- Strengthen housing retention so that, once stably housed, returns to the experience of homelessness are extremely rare.
- Housing programs promote long-term stability, measured by successful program “graduation” to permanent housing and/or housing retention.

- Increase culturally specific organization capacity with increased investments and expanded organizational reach for culturally specific organizations and programs.
- SHS-funded organizations increase equity by hiring a staff that is diverse by race, ethnicity, languages spoken, sexual orientation, gender identity, disability status, age, and lived experience.
- Increase safety, stability and healing for everyone who has experienced homelessness using person-centered, trauma-informed service approaches and connections with mental and physical healthcare.
- Other measures, as determined by Metro, Tri-County data team, and/or Clackamas County community of service providers, will be added.

Coordination:

Partnership and coordination are key components to ending homelessness. A coordinated system makes finding resources easy for potential program participants and allows the entire system to work more smoothly. When done well, a holistic, coordinated approach improves performance system-wide.

The following are effective coordination principles and practices that must be followed. When followed, they ensure system-wide coordination:

- Coordinated Housing Access (CHA) must be utilized to effectively coordinate all housing services. It must be easily accessible and allow participants to complete a single assessment to access all services in the housing continuum.
- Demonstrated partnerships, at all levels of programming, between programs and organizations. Partnerships can be demonstrated through formal contracts, MOUs, system-wide planning participation, and providing infrastructure programming in a coordinated way (including outreach, housing navigation, CHA, and diversion).
- Build connections and coordinate with multiple systems of care (i.e. housing, workforce, education, foster care, DHS, domestic violence, community justice, health, mental health and addictions) to build a community of resources, easily accessible to all.
- Strengthen system capacity by supporting CHA, diversion, outreach and navigation.
- Participate in coordinated system development and implementation, including identifying, addressing, and following-up on unmet needs, gaps in services, and system barriers.

Services:

All services focus on building relationships and service engagement through person-centered, culturally-responsive, trauma-informed, strengths-based practices. Services should align with the Housing First model (see Addendum – Definitions). The purpose of these relationships is to support each household to achieve housing stability through individualized planning and connections with community resources.

To further these services goals, Contractor must follow the following proven practices:

- All services are low-barrier, not requiring pre-requisites to become eligible for services or housing.
- Diversion is attempted at every program “door,” including all immediate housing programs and permanent housing programs, when appropriate.
- Households experiencing or at risk of homelessness must be able to move directly into supportive housing and/or permanent housing without first accessing immediate housing programs. Households must also be presented with available immediate housing options.
- Families will be provided with the option to sleep/stay together; Families will not be separated unless they choose to sleep/stay separately.
- Vulnerable populations are prioritized.

    - Vulnerable populations include those with long homeless histories, incomes below 30% AMI, and one or more disabilities.
    - Due to a long history of systemic racism, oppression, and everyday micro and macro-aggressions, Black, Indigenous, and People of Color are also more vulnerable to the experience of homelessness.
- Services are voluntary, non-intrusive, and provide minimal disruption to meet the expressed needs and desires of the participant.
- Services are highly flexible and tailored to meet the needs of each household.

Participant Voice:

Each individual is the expert in their own life. To build the best system, people with lived experience of homelessness must help to shape the services designed to end homelessness. Contractor must incorporate the following guidelines into all programs:

- Participants lead development of their own individual service plans.
- Ensure that all services are voluntary and that no participant is required to participate in a particular activity in order to receive services.
- Integrate participant (or those who choose not to participate) in decision-making at every level, including program/service development, delivery, and evaluation.
- People with lived experience, who participate in decision-making and program development, should be paid for their time.
- Have written procedures and policies, as well as an accessible and transparent grievance process, that ensure staff and volunteers provide respectful and effective services.

System-wide Service Delivery Expectations (in addition to any items above):

Contractor shall perform the following:

- Participate in the HMIS or, for domestic violence service providers, an HMIS comparable database.
- Provide services free of charge to participants or utilizing a pre-approved sliding scale fee.
- Include sustainable, environmentally friendly practices in business operations and the delivery of services (for example, providing onsite recycling, and encouraging reduction of waste through electronic records whenever possible).
- Confidential information must be protected in compliance with applicable federal, state, and local privacy rules.
- Maintain an effective working relationship. HACC will have formal relationships with service providers through contracts, and will also expect contractors to maintain ongoing communication with the Supportive Housing Services Team about programs and performance, and to engage in community planning and training opportunities.
- All services must be delivered in a wholly secular manner, and programs may not require participation in religious activities for program eligibility purposes.
- Have a written termination and/or exclusion policy that appropriately protects the interests of participants by: (1) applying a trauma and equity lens to evaluating rule violations; (2) imposing sanctions short of termination whenever reasonably possible; (3) informing the participant in clear terms of the reason for their termination and/or exclusion from the program; and (4) outlines the process for grieving the decision. Except in the most extreme situations, termination and exclusion policies should allow for re-entry into the program under appropriate conditions.
- Ensure that staff and volunteers have access to continuing education opportunities.
- Attend training and community/system networking meetings as reasonably required by HACC

Housing Navigation & Placement Program Design

Contractor shall provide a housing navigation and placement program. This program will assist approximately 20 households in moving from the **designated hotel/motel shelter** setting (defined here as the motel shelter program funded directly by Clackamas County as part of its COVID-19 response efforts, or any other motel program funded by Clackamas County with a population served designated by HACC) into permanent rental housing within the Metro jurisdictional boundaries and provide a warm hand-off to the supportive housing case manager assigned to each household (except in cases where both navigation/placement and supportive case management are provided by the same staff). This program will provide connections with supportive services and any necessary re-location navigation, after initial housing placement. The goal will be to move approximately 20 households into permanent housing within six months.

Housing navigation and placement consists of flexible services and funding to assist households in accessing and securing rental housing. Housing navigation and placement is tailored to meet each household's specific needs so they can move into rental housing as quickly as possible.

While it is anticipated some households may not engage with navigation and placement, multiple, progressive efforts will be made to engage each household, currently staying in the hotel/motel program, in a housing search plan. If a household does not find permanent housing, or chooses not to engage with housing navigation and placement services, this program will engage in a harm-reduction conversation and may provide supplies to support the chosen living arrangement. Such provision of supplies will be considered an allowable expense under client assistance flexible funds.

The expected navigator to participant ratio is 1:10.

Housing navigation must include the following:

- Check-ins at least weekly with all participating households.
- Assessment of housing barriers, needs and preferences.
- Support and flexible funds to address immediate housing barriers.
- Assistance attending RLRA briefing(s) and responding to program requirements to secure long term rent assistance.
- Housing search assistance, including researching available units, contacting landlords, accompanying participants on apartment tours, etc.
- Landlord engagement, establishing relationships with landlords to facilitate participant placement.
- Assistance with housing application preparation, housing application appeals and reasonable accommodation requests necessary to obtain housing.

Housing placement must include the following:

- Support with moving assistance, securing furniture, application fees, and other non-rent move-in costs.

Housing Navigation & Placement Program Benchmarks

To indicate program success, Contractor must meet the following benchmarks:

Timeline

1. Hire at least 50% of staff and enroll the first participant within 60 days of Contract execution;
2. Place at least one household into permanent housing within 75 days of Contract execution;

3. Place the higher of 2 households or 10% of total contracted households within 90 days of Contract execution;
4. Place 50% of total contracted households within 90 days of Contract execution;
5. Place 75% of total contracted households within 150 days of Contract execution;
6. Place 100% of total contracted households within 180 days of Contract execution; and
7. Any additional households assigned beyond the contracted number are expected to be placed within 90 days of program enrollment.

*percent based on # of households contracted

The program will be expected to follow the timeline below, meeting each benchmark, as indicated. Unmet benchmarks will result in the following progressive action:

- First time missing a benchmark
    - Monitoring meeting with SHS Team to identify barriers and possible solutions
- Second time missing a benchmark
    - Another monitoring meeting which will result in a mutually agreed upon Performance Improvement Plan (PIP)
- Third time missing a benchmark
    - Another monitoring meeting, including an evaluation of PIP, with all remedies, up to and including Contract termination, available.

HACC will use HMIS data to verify benchmark achievement. Contractor is expected to notify HACC through email within 14 days once staff are hired and if there are challenges in meeting any of the benchmarks above.

Any additional households assigned beyond the contracted number are expected to be placed within 90 days of program enrollment.

Supportive Housing Case Management ("SHCM") Program Design

Contractor shall provide a supportive housing case management program. Supportive housing is affordable housing combined with ongoing services that are flexible, tenant-driven, not time-limited, and voluntary to assist households who are experiencing homelessness in achieving housing stability. This program will assist households, who have recently obtained permanent housing through the Metro 300 and ESG RRH programs, as well as households who have obtained housing from the designated motel shelter program in maintaining that housing within the Metro jurisdictional area. Additionally, this program will work with the navigation program if re-location housing navigation services are needed after initial permanent housing placement.

Those permanently housed by the navigation component in this Contract will receive a warm hand-off into this supportive housing program. Subject to availability of funds, as determined by HACC in its sole administrative discretion, HACC will pay the rental subsidy costs through the Regional Long-term Rental Assistance (RLRA) program. HACC will also provide coordination to support smooth transitions between housing navigation/placement and supportive housing case management.

This program will assist approximately 50 households with supportive housing case management. Households are in scattered-site rental units within the Metro jurisdictional area. The expected case manager to participant ratio is 1:25. As more participants are added to the case load, more staff must be added to accommodate them.

Case management services are dedicated to ensuring participants remain in permanent housing long-term either through on-going housing subsidy and support or by "graduating" from rental subsidy and/or intensive case management.

Specific components of supportive housing case management include, but are not limited to:

- One-on-one case management focused on housing stabilization and lease compliance, offered at least monthly.
- Highly flexible services tailored to meet the needs of each household must be offered.
- Services must be offered based upon the individual's needs and desires. These services must include, but are not limited to:
    - Ongoing relational support
    - Assistance responding to RLRA requirements including inspections and paperwork completion
    - Act as a landlord contact and assist in landlord relationship development
    - Education on tenant and landlord rights and responsibilities
    - Regular communication with the tenant and property management
    - Early intervention and support to address issues that could jeopardize housing stability
    - Problem solving and crisis management
    - Connection to independent living supports and/or provision of life skills training, as needed
    - Connections to education and employment opportunities
    - Assistance, or connections to assistance, with applying for SSI/SSDI, or other benefits, when appropriate
    - Appropriate use of flexible funding to support housing stability goals
    - Assistance with house cleaning and unit maintenance as needed to ensure lease compliance
    - Coordination and connections with other supportive services as needed
    - Plan to "graduate" from housing subsidy and/or intensive housing case management services, as appropriate

Supportive Housing Case Management Benchmarks

To verify program implementation and progress toward participant success, Contractor must meet the following goals:

1. Serve participants, as assigned through case conferencing with partner agencies;
2. Communicate at least monthly with each participating household;
3. Maintain permanent housing for all program participants; and
4. Notify HACC through email if any of the goals above are not met.

If the Contractor fails to meet the requirements in #1 and 2 above, or a participant exits into homelessness (non-permanent housing situation), the following progressive action will result:

- First time failing to meet goals, as outlined above
    - Monitoring meeting with HACC to identify barriers and possible solutions
- Second time failing to meet goals, as outlined above
    - Another monitoring meeting which will result in a mutually agreed upon PIP
- Third time failing to meet goals, as outlined above
    - Another monitoring meeting, including an evaluation of PIP, with all remedies, up to and including contract termination, available

In order to identify met and unmet goals, Contractor will notify HACC through email within the timeline listed below, if any of the following occur:

1. Decline to serve a participant assigned through case conferencing with partner agencies
    a. Contact HACC team within 72 hrs
2. Fail to communicate at least monthly with participants
    a. Contact HACC team within 30 days

3. Exit a participant to a homeless housing situation
    a. Contact HACC team within 72 hrs

Notification with an acceptable explanation may avoid progressive action.

III. **In addition to the obligations set forth above, Contractor shall perform the following:**

1. Incorporate and adhere to the guiding principles and expectations set forth above
2. Equity
    a. In alignment with HACC policies and procedures and in coordination with HACC SHS program staff, develop/implement a plan to ensure culturally responsive service delivery including:
        - Ensure access to services for people who do not speak the primary language of the service provider
        - A plan to provide services equitably to other historically marginalized communities such as LGBTQ2SIA+, youth, people with disabilities, and immigrants and refugees, recognizing intersectionality
        - A quality improvement plan, informed by quantitative and qualitative data analysis, to address evidence of differential access, based on race, ethnicity, disability, gender identity, sexual orientation or other protected class status
        - Ensure that staff and volunteers have access to Equity and Inclusion training on an on-going basis
    b. Prioritize vulnerable populations
        - Vulnerable populations include those with long homeless histories, incomes below 30% AMI, and one or more disabilities
        - Due to a long history of systemic racism, oppression, and everyday micro and macro-aggressions, Black, Indigenous, and People of Color are also more vulnerable to the experience of homelessness
3. Coordination
    a. All program participants must be screened through CHA and effectively matched with the most appropriate and available services.
        - Where participants are already in permanent housing, this step is only appropriate if planning to refer to retention services outside of the Contractor
    b. Participate in coordinated system development and implementation, including identifying, addressing, and following-up on unmet needs, gaps in services, and system barriers.
    c. Attend training, community/system networking meetings, and case conferencing meetings as reasonably required by HACC.

4. Services
    a. In alignment with HACC policies and procedures, develop and implement policies to ensure:
        - Services are aligned with Housing First principles (see Addendum – Definitions)
            - All services are low-barrier, not requiring pre-requisites to become eligible for services or housing
            - Services are voluntary, non-intrusive, and provide minimal disruption to meet the expressed needs and desires of the participant
        - Services are highly flexible and tailored to meet the needs of each household
        - Diversion is attempted at every program “door,” when appropriate
        - Vulnerable populations are prioritized

- Families will be provided with the option to sleep/stay together; Families will not be separated unless they choose to sleep/stay separately
- A written termination and/or exclusion policy that appropriately protects the interests of participants by:
  - applying a trauma and equity lens to evaluating rule violations
  - imposing sanctions short of termination whenever reasonably possible
  - informing the participant in clear terms of the reason for their termination and/or exclusion from the program
  - outlines the process for grieving the decision
  - Except in the most extreme situations, termination and exclusion policies should allow for re-entry into the program under appropriate conditions

5. Participant Voice
   a. In alignment with HACC policies and procedures, develop and implement policies to ensure:
      - Participants lead development of their own individual service plans
      - All services are voluntary and that no participant is required to participate in a particular activity in order to receive services
      - Integrate participants (and/or those who were eligible but did not to participate) in decision-making during program/service development, delivery, and evaluation
      - An accessible and transparent grievance process for both program participants and those who were not offered services. Process must be reviewed and approved by HACC
   b. Administer instrument to gather participant feedback, to be developed in coordination with and reviewed and approved by HACC
   c. People with lived experience, who participate in decision-making and program development, will be paid for their time and expertise
6. General
   a. Provided services will be provided free of charge to participants
   b. Confidential information must be protected in compliance with applicable federal, state, and local privacy rules
   c. All services must be delivered in a wholly secular manner, and programs may not require participation in religious activities for program eligibility purposes
   d. Include sustainable, environmentally friendly practices in business operations and the delivery of services (for example, providing onsite recycling, and encouraging reduction of waste through electronic records whenever possible)
   e. Adhere to all applicable Fair Housing laws
   f. Provide staff and volunteers access to opportunities for continuing education on effective practices and approaches
7. Overall Program-specific
   a. If all contracted households have been served and there is existing staff capacity, Navigation and Placement (NP) and Supportive Housing Case Management (SHCM), will serve additional households in the following manner:
      - Additional households to SHCM will be referred through CHA and supported with NP assistance
      - Absent additional RLRA funds, NP programs will partner with existing housing programs, as directed by SHS team and informed by needs analyses
      - Vulnerable populations will be prioritized
        i. Vulnerable populations include those with long homeless histories, incomes below 30% AMI, and one or more disabilities
        ii. Due to a long history of systemic racism, oppression, and everyday micro and macro-aggressions, Black, Indigenous, and People of Color are also more vulnerable to the experience of homelessness

8. Housing Navigation and Placement Program
    a. Administer the housing navigation and placement program design set forth above
    b. Maintain a provider to participant household ratio of not less than 1:10 unless otherwise authorized by HACC
    c. Assist approximately 20 households in moving from the designated hotel/motel shelter setting into permanent rental housing within the Metro jurisdictional boundaries
    d. Will implement benchmarks as outlined above
    e. Participate in case conferencing meetings to coordinate with partner organizations, including designated COVID hotel/motel shelter provider, and determine which participants will be served by which Contractor.
        - Participant preference will be accommodated, whenever possible
    f. Coordinate and communicate with designated COVID hotel/motel shelter providers to provide a warm hand-off from shelter to navigation and placement services
    g. Provide a warm hand-off to the supportive housing case manager assigned to each household (except in cases where both navigation/placement and supportive case management are provided by the same staff)
    h. Provide connections with supportive services
    i. Provide any necessary re-location navigation, after initial housing placement, as directed by SHS team
    j. Make multiple, progressive efforts to engage each household, currently staying in the hotel/motel program, in a housing search plan
    k. If a household does not find permanent housing, or chooses not to engage with housing navigation and placement services, this program will engage in a harm-reduction conversation and may provide supplies to support the chosen living arrangement.
    l. Provide the following services
        - Check-ins at least weekly with all participating households
        - Assessment of <u>housing</u> barriers, needs and preferences
        - Support and flexible funds to address immediate <u>housing</u> barriers
        - Assistance attending RLRA briefing and responding to program requirements to secure long term rent assistance
        - Housing search assistance, including researching available units, contacting landlords, accompanying participants on apartment tours, etc.
        - Landlord engagement, establishing relationships with landlords to facilitate participant placement
        - Assistance with housing application preparation, housing application appeals and reasonable accommodation requests necessary obtain housing
        - Support with moving assistance, securing furniture, application fees, and other non-rent move-in costs
9. Supportive Housing Case Management (SHCM)
    a. Administer the SHCM program design set forth above
    b. Maintain a provider to participant household ratio of 1:25 unless otherwise approved by HACC
    c. Assist approximately 25 households with supportive housing case management within the Metro jurisdictional boundaries
    d. Will implement goals as outlined in the SHCM goals section
    e. Provide services that are flexible, tenant-driven, not time-limited, and voluntary to assist households who are experiencing homelessness in achieving housing stability
    f. Assist households, who have recently obtained permanent housing through the Metro 300 and ESG RRH programs, in maintaining that housing within the Metro jurisdictional area
    g. Accept a warm hand-off from the navigation and placement program
    h. If relocation housing navigation services are needed after initial placement, work with the navigation program within the Contractor to successfully relocate
    i. Specific components of supportive housing case management shall include, but are

not limited to:

- One-on-one case management focused on housing stabilization and lease compliance, offered at least monthly
- Services must be offered based upon the individual's needs and desires. These services must include, but are not limited to:
    i. Ongoing relational support
    ii. Assistance responding to RLRA requirements including inspections and paperwork completion
    iii. Act as a landlord contact and assist in landlord relationship development
    iv. Education on tenant and landlord rights and responsibilities
    v. Regular communication with the tenant and property management
    vi. Early intervention and support to address issues that could jeopardize housing stability
    vii. Problem solving and crisis management
    viii. Connection to independent living supports and/or provision of life skills training, as needed
    ix. Connections to education and employment opportunities
    x. Assistance, or connections to assistance, with applying for SSI/SSDI, or other benefits, when appropriate
    xi. Appropriate use of flexible funding to support housing stability goals
    xii. Assistance with house cleaning and unit maintenance as needed to ensure lease compliance
    xiii. Coordination and connections with other supportive services as needed
    xiv. Create a plan to "graduate" from housing subsidy and/or intensive housing case management services for each household
        a. All households identified as meeting Population B (defined here as households who are experiencing or at risk of experiencing homelessness who are otherwise not Population A) will have a plan to "graduate" from subsidy and intensive case management
        b. Households identified as meeting the Population A (defined here as households experiencing or at imminent risk of experiencing long term homelessness, with one or more disabling conditions, and who have incomes less than 30% AMI) will have a plan to "graduate" from subsidy and/or intensive case management, as appropriate
    xv. Provide on-going, limited housing retention and crisis intervention to those who have "graduated" from intensive services, but continue to require a rental subsidy

j. Provide case management services dedicated to ensuring participants remain in permanent housing long-term either through on-going housing subsidy and support or by "graduating" from rental subsidy and/or intensive case management

IV. HACC SHS team responsibilities:

1. Incorporate and adhere to the guiding principles and expectations set forth above
2. Adhere to all applicable Fair Housing laws
3. Support in creating policy manual, including sharing examples
4. Provide quarterly "data report cards" pulled and analyzed from HMIS, including equity data
5. Provide HMIS access, training, and support
6. Provide connections to CHA and diversion training
7. Coordination, support, and/or facilitation of provider meetings, including case

conferencing meetings, as needed
8. SHCM- pay monthly rental subsidies and deposits directly to the landlord with RLRA program
9. Provide information, access, and/or support for staff to attend Equity, Inclusion and continuing education trainings
10. Connect NP and SHCM programs with the overall system of services for people experiencing homelessness
11. Support both formal and informal partnerships between provider organizations, including those newly formed
12. Facilitate connections to broader systems of care, including but not limited to:
    a. Housing
    b. Workforce
    c. Education
    d. Foster care
    e. Department of Human Services
    f. Domestic Violence
    g. Community corrections
    h. Healthcare, both physical and mental
    i. Substance use Disorder treatment
13. Identify unmet needs, gaps in services and system barriers and address these with the system of providers
14. Provide case staffing, either in a group of service provider peers or one-on-one, as needed
15. Assist with program access prioritization, as needed
16. Incorporate participant voice in SHS programming decisions
17. Maintain effective working relationships with contracted providers
18. Attend training and community/systems meetings
19. If all hotel/motel program participants have moved out of the hotel/motel, and there is additional funding for navigation and placement, direct NP programs to partner with other existing housing programs
20. Give at least 30 days' notice for changes in program participant demographics
21. Provide or assist with creation of necessary participant/program forms
22. Support Contractor in identifying households in the designated COVID hotel/motel program who may be a better fit for STRA/RRH than RLRA with on-going supportive housing case management
23. Coordinate with Contractor to serve people on CHA waitlists, if necessary
24. Apply the process as outlined in Navigation and Placement Benchmark and the SHCM goals sections described above

V. Reporting Requirements

Contractor will:

1. Participate in the HMIS or, for domestic violence service providers, an HMIS comparable database
    a. Complete all necessary initial HMIS data entry training within one month of contract execution
    b. Collect participant demographics and enter data electronically into HMIS into appropriate HMIS providers, which will be determined by HACC
    c. comply with current HMIS Policy and Procedures and adhere to all HMIS reporting requirements
    d. Ensure that data entry into HMIS occurs in an accurate and timely manner within three (3) business days of program entry date
    e. Correct data quality, missing information, and null data errors as specified by SHS Data team within 14 days after the end of each fiscal quarter or as requested.
    f. Collect, at minimum, universal data elements which include demographic information on all clients at entry

g. Comply with all confidentiality policies and procedures regarding HMIS and the use of participant data
h. Ensure only authorized Contractor staff, trained by HACC, shall access the HMIS software

2. Complete narrative sections of quarterly "report cards" within 30 days of receipt
3. Quarterly "report cards" will include, at a minimum, but not limited to the following data categories:
    a. HMIS data quality: % missing
    b. Participant demographic data, including race and ethnicity
        i. All data points listed below will include a breakdown of demographic characteristics related to race and ethnicity
    c. Navigation and Placement
        i. Number of households served
        ii. Length of time from program enrollment to permanent housing placement
        iii. Number of households placed
        iv. Number of relocations requested vs completed
    d. Supportive Housing Case Management
        i. Number of households served
        ii. Bed/Unit utilization
        iii. Rates of Permanent Housing
            1. Maintenance of housing in program
            2. Exits to other permanent housing
            3. Relocations within program to another PH unit
            4. Post-exit follow-up PH retention rates
        iv. Rates of increased access to income and benefits
    e. Narrative responses to questions that align with the Guiding Principles and Expectations
4. Work with HACC to finalize, then continually improve the quarterly "report card" template
5. Work with HACC to finalize, then continually improve on performance targets
6. Conduct post-program exit follow-up assessments at 6 and 12 months post-exit
    a. Enter the results into HMIS
7. Prepare an annual participant feedback report
8. Submit to monitoring for contract compliance

HACC will:

1. Work with Contractor to continuously monitor demographics and outcomes, and to create any necessary quality improvement plans
2. Assist with achieving desired program outcomes and improving those outcomes
3. Communicate with Contractor in a timely manner when additional data metrics are determined
4. Use HMIS data to create and provide quarterly "report card" to Contractor
5. Work with SHS-funded agencies, as a group, to finalize, then continually improve the quarterly "report card" template
6. Work with HACC to finalize, then continually improve on performance targets
7. Work with Contractor to identify strengths and weaknesses apparent in programming through data
8. Review and identify strengths and weaknesses from participant feedback report with Contractor
9. Monitor for contract compliance

Program Design

If all contracted households have been served and there is existing staff and funding capacity, Navigation and Placement (NP) and Supportive Housing Case Management (SHCM), will serve additional households in the following manner:

- Additional households to SHCM will be referred through CHA and supported with NP

assistance.

- Absent additional RLRA funds, NP programs will partner with existing housing programs, as directed by SHS team and informed by needs analyses.
- Vulnerable populations will be prioritized
    - Vulnerable populations include those with long homeless histories, incomes below 30% AMI, and one or more disabilities.
    - Due to a long history of systemic racism, oppression, and everyday micro and macro-aggressions, Black, Indigenous, and People of Color are also more vulnerable to the experience of homelessness.

EXHIBIT B
PERSONAL SERVICES CONTRACT
BUDGET

RFP #06-2021 Budget			
Line Item Category	**Narrative/Description**	**Funds Requested**	
Housing Navigation/Placement Services			
Staff Salaries	2 FTE @ 41,600/FTE + .25 program supervision @ 55,000	$	96,950.00
Fringe Benefits	Health benefits + retirement	$	26,938.00
Taxes	state and federal tax withholdings	$	12,320.00
Telecommunications	internet and telephone	$	1,487.00
Office Equipment	computers for new staff	$	4,250.00
Office Supplies	costs for client files, paper, basic supplies	$	1,900.00
Mileage	mileage reimbursement @ .56/mile + $111 in parking	$	2,926.00
Insurance			
Office Occupancy/Rent	total rent + utilities shared across FTE @ 357.33/FTE/Mo	$	9,648.00
Program Expenses	program printing and copying + materials	$	1,500.00
Client Move-in Costs			
Relocation Costs	Funds for the potential relocation of households currently in housing which need to be placed in a new unit.	$	10,000.00
Client Services/Flexible Funding	Funds for the assistance of households in meeting basic needs	$	37,500.00
	Housing Navigation/Placement Subtotal:	$	205,419.00
Supportive Housing Case Management Services			
Staff Salaries	2 FTE @ 41,600/FTE + .25 program supervision @ 55,000	$	96,950.00
Fringe Benefits	Health benefits + retirement	$	26,938.00
Taxes	state and federal tax withholdings	$	12,321.00
Telecommunications	internet and telephone	$	1,487.00
Office Equipment	computers for new staff	$	4,250.00
Office Supplies	costs for client files, paper, basic supplies	$	1,900.00
Mileage	mileage reimbursement @ .56/mile + $111 in parking	$	2,926.00
Insurance			
Office Occupancy/Rent	total rent + utilities shared across FTE @ 357.33/FTE/Mo	$	9,648.00
Program Expenses	program printing and copying + materials	$	1,500.00
Client Services/Flexible Funding	Funds for the assistance of households in meeting basic needs	$	37,500.00
	Supportive Housing Case Management Subtotal:	$	195,420.00
Administration			
Indirect Administration	admin rate covers finance, HR, QA, payroll, program oversight	$	59,078.00
	Administration Subtotal:	$	59,078.00
Capacity Building For Culturally Specific Providers			
Education/Training	staff training with average of $750/FTE	$	3,000.00
	Capacity Building for Culturally Specific Providers Subtotal	$	3,000.00
	Total Funds Requested	**$**	**462,917.00**

EXHIBIT C
PERSONAL SERVICES CONTRACT
INVOICE TEMPLATE

Health, Housing & Human Services
CLACKAMAS COUNTY

INVOICE

FYXX (xx/xx/xxxx–xx/xx/xxxx)

Fill in actual costs & submit electronically to HACCSHS@clackamas.us

Contractor: _____ Billing Period (Month/Year): _____

Project: _____ Contractor Invoice #: _____

Address: _____ Contract #: _____

_____

Contact: _____ Contract $ Maximum: _____

Phone #: _____ Contract Term: _____

Email:

Date(s) of Goods/Services	Description - Please provide a *detailed* description of each line item including client name *supplemental attachments are required for personnel and mileage reimbursements*	Contracted Budget Line Item Category	Population A/B	Funds Requested
Housing Navigation/Placement Services				
			Housing Navigation/Placement Subtotal:	$ -
Supportive Housing Case Management Services				
			Supportive Housing Case Management Subtotal:	$ -
Indirect Administration				
			Administration Subtotal:	$ -
Capacity Building For Culturally Specific Providers				
			Capacity Building for Culturally Specific Providers Subtotal	$ -
Short-term Rent Assistance				
			Short Term Rent Assistance Subtotal	$ -
			Total Funds Requested	**$ -**

This form derives from the approved budget in your Agreement/Contact. Expenditures must have adequate supporting documentation. Clackamas County retains the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of Recipient pertinent to this Agreement/Contract.

PAYMENT TERMS: Submit itemized invoices by the 20th day of the month following the month services were performed.

CERTIFICATION: I certify that this report is true and correct to the best of my knowledge and that all expenditures reported have been made in accordance with the budget and other provisions contained in the Agreement/Contract.

Prepared by: _____

Authorized Signer: _____ **Date:** _____

HOUSING AUTHORITY OF CLACKAMAS COUNTY, ACCOUNTS PAYABLE
13930 Gain St, Oregon City, OR 97045 | Direct Line: (503) 655-8267 | Fax: (503) 655-8676 | HACCSHS@clackamas.us

Mileage Reimbursement Supplemental Form

FYXX (xx/xx/xxxx–xx/xx/xxxx)

Fill in actual costs & attach to the associated invoice

Contractor _____ Billing Period (Month/Year) _____

Project _____ Contractor Invoice # _____

Address _____ Contract # XXXX

Contact _____

Phone # _____

Email _____

Date of Travel	Name of Personnel and Client Served	# of miles traveled	Funds Requested
			$
			$
			$
			$
			$
			$
		Mileage Subtotal	**$**

This form derives from the approved budget in your Agreement/Contact. Expenditures must have adequate supporting documentation. Clackamas County retains the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of Recipient pertinent to this Agreement/Contract.

PAYMENT TERMS: Submit itemized invoices by the 20th day of the month following the month services were performed.

CERTIFICATION: I certify that this report is true and correct to the best of my knowledge and that all expenditures reported have been made in accordance with the budget and other provisions contained in the Agreement/Contract.

Prepared by: _____

Authorized Signer: _____ **Date:** _____

HOUSING AUTHORITY OF CLACKAMAS COUNTY, ACCOUNTS PAYABLE

13930 Gain St, Oregon City, OR 97045 | Direct Line: (503) 655-8267 | Fax: (503) 655-8676 HACCSHS@clackamas.us

Personnel Reimbursement Supplemental Form
FYXX (xx/xx/xxxx–xx/xx/xxxx)

Fill in actual costs & attach to the associated invoice

Contractor _____ Billing Period (Month/Year) _____

Project _____ Contractor Invoice # _____

Address _____ Contract # XXXX

_____

Contact _____

Phone # _____

Email _____

Days Worked	Name of Personnel	# of Hours Worked	Hourly Rate	Funds Requested
				$
				$
				$
				$
				$
				$
				$
				$
			Personnel Subtotal	**$**

This form derives from the approved budget in your Agreement/Contact. Expenditures must have adequate supporting documentation. Clackamas County retains the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of Recipient pertinent to this Agreement/Contract.

PAYMENT TERMS: Submit itemized invoices by the 20th day of the month following the month services were performed.

CERTIFICATION: I certify that this report is true and correct to the best of my knowledge and that all expenditures reported have been made in accordance with the budget and other provisions contained in the Agreement/Contract.

Prepared by: _____

Authorized Signer: _____ **Date:** _____

HOUSING AUTHORITY OF CLACKAMAS COUNTY, ACCOUNTS PAYABLE
13930 Gain St, Oregon City, OR 97045 | Direct Line: (503) 655-8267 | Fax: (503) 655-8676 |HACCSHS@clackamas.us

EXHIBIT D
PERSONAL SERVICES CONTRACT
DEFITIONS

Culturally Responsive and Culturally Specific Services

HACC is using definitions of Culturally Responsive and Culturally Specific services developed through a collaborative Metro-wide work group.

Culturally Responsive
Culturally responsive services are general services that have been adapted to honor and align with the beliefs, practices, culture and linguistic needs of diverse consumer / client populations and communities whose members identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home. Culturally responsive services also refer to services provided in a way that is culturally responsive to the varied and intersecting "biological, social and cultural categories such as gender identity, class, ability, sexual orientation, religion, caste, and other axes of identity." Culturally responsive organizations typically refer to organizations that possess the knowledge and capacity to respond to the issues of diverse, multicultural communities at multiple intervention points. Culturally responsive organizations affirmatively adopt and integrate the cultural and social norms and practices of the communities they serve. These agencies seek to comprehensively address internal power and privilege dynamics throughout their service delivery, personnel practices and leadership structure.

A culturally responsive organization is one that reflects the following characteristics:

• Prioritizes responsivity to the interests of communities experiencing inequities/racism and provides culturally grounded interventions [that] have been designed and developed starting from the values, behaviors, norms, and worldviews of the populations they are intended to serve, and therefore most closely connected to the lived experiences and core cultural constructs of the targeted populations and communities;

• Affirmatively adopts and integrates the cultural and social norms and practices of the communities they serve;

• Addresses power relationships comprehensively throughout its own organization, through both the types of services provided and its human resources practices. A key way of doing this is engaging in critical analysis of the organization's cultural norms, relationships, and structures, and promoting those that support democratic engagement, healing relationships and environments;

• Values and prioritizes relationships with people and communities experiencing inequities universally, paying particular attention to communities experiencing racism and discrimination;

• Commits to continuous quality improvement by tracking and regularly reporting progress, and being deeply responsive to community needs; and

• Strives to eliminate barriers and enhance what is working.
Culturally responsive organizations seek to build change through these major domains:

• Organizational commitment, leadership, and governance;

• Racial equity policies and implementation practice;

• Organizational climate, culture, and communications;

• Service-based equity and relevance;

• Workforce composition and quality;

• Community collaboration;

• Resource allocation and contracting practices; and

• Data metrics and continuous quality improvement.

Culturally Specific

Culturally specific services are services provided for specific populations based on their particular needs, where the majority of members/clients are reflective of that community, and use language, structures and settings familiar to the culture of the target population to create an environment of belonging and safety in which services are delivered. Culturally specific organizations typically refer to organizations with a majority of members/clients from a particular community. Culturally specific organizations also have a culturally focused organizational identity and environment, a positive track record of successful community engagement, and recognition from the community served as advancing the best interests of that community. Organizations providing Culturally Specific Services reflect the following characteristics:

• Programs are designed and continually shaped by community input to exist without structural, cultural, and linguistic barriers encountered by the community in dominant culture services or organizations AND designed to include structural, cultural and linguistic elements specific to the community's culture which create an environment of accessibility, belonging and safety in which individuals can thrive.

• Organizational leaders, decision-makers and staff have the knowledge, skills, and abilities to work with the community, including but not limited to expertise in language, core cultural constructs and institutions; impact of structural racism, individual racism and intergenerational trauma on the community and individuals; formal and informal relationships with community leaders; expertise in the culture's explicit and implicit social mores. Organizational leaders and decision-makers are engaged in improving overall community well-being, and addressing root causes.

• Intimate knowledge of lived experience of the community, including but not limited to the impact of structural or individual racism or discrimination on the community; knowledge of specific disparities documented in the community and how that influences the structure of their program or service; ability to describe the community's cultural practices, health and safety beliefs/practices, positive cultural identity/pride/resilience, immigration dynamics, religious beliefs, etc., and how their services have been adapted to those cultural norms.

• Provide multiple formal and informal channels for meaningful community engagement, participation and feedback at all levels of the organization (from service complaints to community participation at the leadership and board level). Those channels are constructed within the cultural norms, practices, and beliefs of the community, and affirm the positive cultural identity/pride/resilience of the community. Community participation can and does result in desired change.

• Commitment to a highly skilled and experienced workforce by employing robust recruitment, hiring and leadership development practices including but not limited to valuing and caring for community and/or lived experience; requirements for professional and personal references within the community; training standards professional development opportunities and performance monitoring.

• Commitment to safety and belonging through advocacy; design of services from the norms and worldviews of the community; reflect cultural constructs of the culturally specific community; understand and incorporate shared history; create rich support networks; engage all aspects of community; and address power relationships.

Housing First Principles:

- Few to no programmatic prerequisites to permanent housing entry
- Low barrier admission policies
- Rapid and streamlined entry into housing
- Supportive services are voluntary, but can and should be used to persistently engage tenants to ensure housing stability
- Tenants have full rights, responsibilities, and legal protections
- Practices and policies to prevent lease violations and evictions
- Evictions from housing do not result in termination from the program

For more information on housing first, visit: https://endhomelessness.org/resource/housing-first/ and https://www.hudexchange.info/resource/3892/housing-first-in-permanent-supportive-housing-brief/

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Subrecipient Agreement with Clackamas Women's Services to Provide Homeless Shelter Services – Children's Programing 2021.
No County General Funds are involved.

Purpose/ Outcome	Signature approval of an agreement to provide funding for the education and services to be provided to children in a homeless shelter who are also overcoming sexual and domestic violence trauma.
Dollar Amount and Fiscal Impact	Community Development Block Grant (CDBG) FY21 funds of $15,000 as a grant. No County General Funds are included in this Agreement.
Funding Source	U.S. Department of Housing and Urban Development (HUD)
Duration	July 1, 2021 to June 30, 2022
Previous Board Action/ Review	BCC Public Hearing on April 8, 2021. May 6, 2021 BCC Approval of the 2021 Action Plan which included $50,000 for the Annie Ross House shelter.
Strategic Plan Alignment	Build a Strong Infrastructure. Ensure Safe, Healthy and Secure Communities.
County Review	1. The Subrecipient Agreement was reviewed and approved by County Counsel AN on October 26, 2021.
Procurement Review	1. Was the ítem processed through Procurement? *yes* ☐ *no* ✓ 2. Item is a Subrecipient that was processed through Finance Grant Management
Contact Person	Mark Sirois, Manager - Community Development: 503-351-7240
Contract No.	H3S #10430 Subrecipient Agreement 22-018

BACKGROUND: The Community Development Division of the Health, Housing and Human Services Department requests the approval of a Sub-recipient Agreement for the purpose to provide education and services to children recovering from sexual and domestic violence who are housed in a domestic violence shelter located in Oregon City, OR, 97045. In 2019 Clackamas Women's Services (CWS) applied for Community Development Block Grant (CDBG) funding to provide children's programing at homeless shelter.

PROJECT OVERVIEW: The CWS shelter will provide children's education and awareness services to individuals and families as related to overcoming trauma.

It is expected that the funding under this CDBG contract will assist approximately 60 homeless families during the program year.

RECOMMENDATION: We recommend the signature approval of this Sub-recipient Agreement.

Respectfully submitted,

Mary Rumbaugh

Rodney A. Cook, Director
Health, Housing Human Services

CLACKAMAS COUNTY, OREGON
SUBRECIPIENT GRANT AGREEMENT 22-018

Project Name: ***CDBG FY2021 CWS – Children's Programming***
Project Number: ***6402 22200 - 1800***

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

Clackamas County Data	
Grant Accountant: ***Bouavieng Bounnam***	Program Manager: ***Amy Counsil***
Clackamas County – Finance 2051 Kaen Road Oregon City, OR 97045 Phone: 503-742-5422 Email: bbounnam@clackamas.us	Clackamas County – Community Development 2051 Kaen Road, Suite 245 Oregon City, OR 97045 Phone: 971-349-2949 Email: acounsil@clackamas.us
Subrecipient Data	
Finance/Fiscal Representative: ***Carla Batcheller***	Program Representative: ***Angie Drake***
Clackamas Women's Services 256 Warner Milne Road Oregon City, OR 97045 Phone: 503-655-8600 Email: carlab@cwsor.org	Clackamas Women's Services 256 Warner Milne Road Oregon City, OR 97045 Phone: 503-655-8600 Email: angied@cwsor.org
DUNS: 959059759	

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 Federal Community Development Block Grant program ("CDBG") contained in U.S. Department of Housing and Urban Development ("HUD"), and regulations adopted under this Act at Subchapter C, 24 CFR Part 570, dated 1974, as amended, and Public Law 93-383 as amended. The program is designed to provide CDBG funds to SUBRECIPIENT to support homelessness prevention by securing funds to provide for staffing and program expenses at a local domestic violence shelter.
2. COUNTY has applied for and expects to receive CDBG funds from HUD under Title I of the Housing and Community Development Act of 1974, Public Law 93-383 ("ACT").
3. Funds provided by COUNTY shall be used for expenditures for **CWS Homeless Shelter,** in Oregon City, OR, a domestic violence homeless shelter and funding is for the Children's Program which provides education and services that help children overcome the trauma of domestic and sexual violence.
4. In response to a Congressional directive, HUD has required all recipients to use funds provided pursuant to this Agreement for eligible activities as described in 24 CFR 570.201 (e), and agrees not to use such funds for any ineligible activity described in 24 CFR 570.207.

5. SUBRECIPIENT shall expend CDBG funds to support the staffing and operations of a homeless shelter program benefiting homeless participants of the Children's Program. Documentation shall be provided through submission of quarterly reports on CWS House activities and persons served as related to the Children's Program. The report is included as Attachment A and shall be submitted to the COUNTY with each quarterly invoice.

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 Program (described below) incurred no earlier than **July 1, 2021** and not later than **June 30, 2022**, unless this Agreement is sooner terminated or extended pursuant to the terms hereof. No grant funds are available for expenditures after the expiration date of this Agreement.

2. **Program.** The Program is described in the attached Exhibit A: Subrecipient Scope of Work. 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 C of Title I of the Housing and Community Act of 1974. Furthermore, SUBRECIPIENT shall comply with the requirements of CDBG award number B21-UC-41-0001 that is the source of the grant funding, in addition to compliance with requirements of Title I of the *Code of Federal Regulations* ("CFR"), Part 24, Sub-Part 570. 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, 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 Community Development Block Grant (Assistance Listing #: 14.218) issued to COUNTY by the U.S. Department of Housing and Urban Development, Office of Community Planning and Development (Federal Award Identification #B21-UC-41-0001). The maximum, not to exceed, grant amount COUNTY will pay is **$15,000.** 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.

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 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.
c. Written notice provided by COUNTY that HUD has determined CDBG funds are no longer available for this purpose.
d. Written notice provided by COUNTY that it lacks sufficient funds, as determined by COUNTY in its sole discretion, to continue to perform under this Agreement.

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

7. **Effect of Termination**. The expiration or termination of this Agreement, for any reason, shall not release SUBRECIPIENT from any obligation or liability to COUNTY, or any requirement or obligation that:
   a. Has already accrued hereunder;
   b. Comes into effect due to the expiration or termination of the Agreement; or
   c. Otherwise survives the expiration or termination of this Agreement.

   Following the termination of this Agreement, SUBRECIPIENT shall promptly identify all unexpended funds and return all unexpended funds to COUNTY. Unexpended funds are those funds received by SUBRECIPIENT under this Agreement that (i) have not been spent or expended in accordance with the terms of this Agreement; and (ii) are not required to pay allowable costs or expenses that will become due and payable as a result of the termination of this Agreement.

8. **Funds Available and Authorized.** COUNTY certifies that 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.

9. **Future Support.** COUNTY makes no commitment of future support and assumes no obligation for future support for the activity contracted herein except as set forth in Section 8.

10. **Nonprofit status.** SUBRECIPIENT warrants that it is, and shall remain during the performance of this Agreement, a private nonprofit Organization as defined in the Regulations, including:
    a. That it is described in Section 501(c) of the Internal Revenue Code of 1954;
    b. That it is exempt from taxation under Subtitle A of the Internal Revenue Code of 1954;
    c. That it has an accounting system and a voluntary board; and
    d. That it practices nondiscrimination in the provision of assistance to the homeless.

11. **Administrative Requirements**. SUBRECIPIENT agrees to its status as a subrecipient, and accepts among its duties and responsibilities the following:

    a) **Financial Management.** SUBRECIPIENT shall comply with 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) **Change in Key Personnel.** SUBRECIPIENT is required to notify COUNTY, in writing, whenever there is a change in SUBRECIPIENT key administrative or programmatic personnel and the reason for the change. Key personnel include but are not limited to: Executive Director, Finance Director, Program Manager, Bookkeeper, or any equivalent to these positions within the organization.

    c) **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 570 Subpart C.

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

e) **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.

f) **Indirect Cost Recovery.** SUBRECIPIENT claims a portion of its provisional negotiated indirect cost rate (25.6% of salary/fringe) negotiated with the Department of Justice Office on Violence Against Women, dated May 10, 2021 as indicated in Exhibit B: Budget.

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

h) **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.

i) **Performance Reporting.** HMIS reporting is not a requirement of this Agreement.

j) **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.

k) **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.

l) **Specific Conditions.** None.

m) **Grantor Recognition.** SUBRECIPIENT shall ensure 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.

n) **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.

o) **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 200.344—*Closeout*. SUBRECIPIENT must liquidate all obligations incurred under this award and must submit all financial (Exhibit E), 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.

p) **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.

q) **Suspension and Debarment.** SUBRECIPIENT shall comply with 2 CFR Part 180. These rules 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 http://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.

r) **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.

s) **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, 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 the SUBRECIPIENT'S fiscal year end or 30 days after issuance of the reports, whichever is sooner.

t) **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 the 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.

u) **Records to be Maintained.** SUBRECIPIENT shall maintain all records required by the Federal regulations specified in 24 CFR 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 CDBG 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 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)(7), as applicable.

v) **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.

w) **Fiduciary Duty.** SUBRECIPIENT acknowledges that it has read the award conditions and certifications for the CDBG, 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 the Clackamas County, as COUNTY, under those grant documents.

x) **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, terminate this Agreement and all associated amendments, reclaim grant funds in the case of omissions or misrepresentations in financial or programmatic reporting, require repayment of any funds used by SUBRECIPIENT in violation of this Agreement, to terminate this Agreement, and to pursue any right or remedy available to COUNTY at law, in equity, or under this Agreement.

y) **Program Income**. SUBRECIPIENT shall report monthly all program income as defined at 2 CFR 200.307 generated by activities carried out with CDBG 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.

12. Compliance with Applicable Laws

a) **Public Policy**. SUBRECIPIENT expressly agrees to comply with all public policy requirements, laws, regulations, and executive orders issued by the Federal government, to the extent they are applicable to the Agreement: (i) Titles VI and VII of the Civil Rights Act of 1964, as amended; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Americans with Disabilities Act of 1990, as amended; (iv) Executive Order 11246, "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 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.** Except as may be permitted under applicable law, any confidential or personally identifiable information (as defined under 2 CFR 200.1) acquired by SUBRECIPIENT during the execution of the project should not be disclosed during or upon termination or expiration of this Agreement. 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.

13. 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.

14. **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 elected officials, 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 (1) SUBRECIPIENT's negligent or willful acts or those of its employees, agents or those under SUBRECIPIENT's control; or (2) SUBRECIPIENT's performance under this Agreement including, but not limited to, any claim by a State or Federal funding source that SUBRECIPIENT used funds for an ineligible purpose. 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 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) **Abuse and Molestation Insurance.** Abuse and molestation insurance as part of the Commercial General Liability policy in a form and with coverage that are satisfactory to the County covering damages arising out of actual or threatened physical abuse, mental injury, sexual molestation, negligent: hiring, employment, supervision, investigation, reporting to proper authorities, and retention of any person for whom the Contractor is responsible including but not limited to Contractor and Contractor's employees and volunteers. Policy endorsement's definition of an insured shall include the Contractor, and the Contractor's employees and volunteers. Coverage shall be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Any annual aggregate limit shall not be less than $3,000,000.

5) **Additional Insured Provisions**. All required insurance, other than Professional Liability, Workers' Compensation, and Personal Automobile Liability and Pollution Liability Insurance, shall include "Clackamas County, its agents, commissioners, officers, and employees" as an additional insured.

6) **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.

7) **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.

8) **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.

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

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

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

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

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

15. 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.

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 Subpart B apply to SUBRECIPIENT and program income is to be used as the nonfederal share. 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 570.200 (j)(3)

f) **Environmental review responsibilities**.

1) 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").

2) 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 these public services in the CDBG 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 CDBG, 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 CDBG.

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 CDBG funds, or be required to move to another unit in the same building/complex. When a tenant moves for a project assisted with CDBG 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 (URA), and implementing regulations at 49 CFR Part 24 and (b) the requirements of 24 CFR 570.606 governing the CDBG 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 a CDBG-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 570.606 and such assistance shall be subtracted from the CDBG 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 CDBG 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 CDBG 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.

16. 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 HUD 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.

17. 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 the agency Agreementing officer, 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.

18. 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 journeyworkers; 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**. SUBRECIPIENT, and any of SUBRECIPIENT's subrecipients or subcontractors, shall comply with the provisions of Section 3 of the Housing and Urban Development Act of 1968, as amended by the Housing and Community Development Act of 1992 ("Section 3"), the regulations set forth in 24 CFR, Subtitle A, Part 75, and all applicable rules and orders issued hereunder prior to the execution of this Agreement. Failure to fulfill these requirements shall subject 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 other

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 within the metropolitan area in which the CDBG 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 CDBG-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 agreement or other 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 Part 75 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.

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

20. **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.

21. **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.

22. **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.

23. **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.

24. **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.

25. **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.

26. **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.

(Signature Page Follows)

SIGNATURE PAGE TO SUBRECIPIENT GRANT AGREEMENT

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers.

CLACKAMAS WOMEN'S SERVICES

DocuSigned by:
By: _____ DBCAD1860649464...
Melissa Erlbaum
Executive Director

Melissa Erlbaum 10/29/2021

Printed Name Date

256 Warner Milne Road

Street Address

Oregon City, OR 97045

City / State / Zip

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

Tootie Smith, Chair
Board of County Commissioners

Date

Approved to Form:

Andrew Naylor via email
County Counsel

10/26/2021
Date

- Exhibit A. SUBRECIPIENT Scope of Work
- Exhibit B: SUBRECIPIENT Program Budget
- Exhibit C: Lobbying Certificate
- Exhibit D: Required Financial Reporting and Reimbursement Request
- Exhibit E: Final Financial Report
- Attachment A: Community Development Block Grant – Annual Report

EXHIBIT A

SUBRECIPIENT SCOPE OF WORK

1. Scope of Work for: Clackamas Women's Services – Children's Programming 2021

These CDBG funds are to be used to prevent, prepare for, and respond to homelessness prevention among individuals and families who are homeless or receiving homeless assistance; and to support additional homeless assistance and homelessness prevention activities. SUBRECIPIENT agrees to accomplish the following work under this Agreement:

A. Provide emergency shelter services to homeless families by paying for staff and other operational expenses.

B. It is expected that the funding under this CDBG contract will assist approximately 60 homeless families with shelter services during the program year.

2. SUBRECIPIENT agrees to use funds provided pursuant to this Agreement for eligible activities as described in 24 CFR 570.201 (c), and agrees not to use such funds for any ineligible activity described in 24 CFR 570.207.

3. SUBRECIPIENT shall expend CDBG funds to support the staffing and operations of a homeless shelter benefiting homeless persons. Documentation shall be provided through submission of quarterly reports on all Annie Ross House activities and persons served. The report is included as Attachment A and shall be submitted to COUNTY with each quarterly invoice.

4. 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.

5. COUNTY agrees to apply for and administer CDBG funds received under the ACT, and to provide funds to SUBRECIPIENT pursuant to this Agreement.

EXHIBIT B

SUBRECIPIENT PROGRAM BUDGET

A. The total compensation under this contract shall not exceed $15,000 for the fiscal year with payments to be made as outlined in the body of this Agreement.

B. Adjustments to the budget may only be made with the approval of both Parties.

Budget Category	Maximum Expenditure FY21
Personnel	$11,900
Program Supplies	$54
Indirect Costs*	$3,046
TOTAL	$15,000

*SUBRECIPIENT claims a portion of their federally-negotiated indirect cost rate of 25.6% of salary/fringe, negotiated with the DOJ Office on Violence Against Women (provisional rate; date May 10, 2021)

EXBHIBIT C: CONGRESSIONAL LOBBYING CERTIFICATE

The undersigned certifies, to the best of his or her knowledge and belief, that:

No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions[as amended by "Government-wide Guidance for New Restrictions on Lobbying," 61 Federal Regulations 1413 (1/19/96). Note: Language in paragraph (2) herein has been modified in accordance with Section 10 of the Lobbying Disclosure Act of 1995 (P.L. 104-65, to be codified at 2 U.S.C. 1601, et seq.)].

The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered intro. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code (as amended by the Lobbying Disclosure Act of 1995). Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

[Note: Pursuant to 31 U.S.C. §1352(c)(1)-(2)(A), any person who makes a prohibited expenditure or fails to file or amend a required certification or disclosure form shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each expenditure or failure.]

The Authorized Representative certifies or affirms the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, the Organization understands and agrees that the provisions of 31 U.S.C. §3801, et seq., apply to this certification and disclosure, if any.

Clackamas Women's Services	22-2018
Organization Name	Award Number or Project Name
Melissa Erlbaum	Executive Director
Name and Title of Authorized Representative	
DocuSigned by: DBCAD1860649464...	10/29/2021
Signature	Date

Exhibit D
REQUEST FOR REIMBURSEMENT

Note: This form derives from the approved budget in your grant Agreement. Please follow instructions for completing this form as outlined in Exhibit D.1.

Subrecipient	Clackamas Women's Services	**Grant Number:**	**22-018**
Address:		**Report Period:**	
		Contract #:	
Contact Person:		**Federal Award #:**	B21-UC-41-0001
Phone Number:		**CFDA(s):**	14.218
E-mail:			

Budget Category	Budget	Current Draw Request	Previously Requested	Balance
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -
Total Grant Funds Requested	**$ -**	**$ -**	**$ -**	**$ -**

ATTACH ALL RECEIPTS AND REQUIRED CLIENT DOCUMENTATION.

Clackamas County and the Federal government retain the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of Recipient that are pertinent to this Agreement.

CERTIFICATION

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

Prepared by: _____

Authorized Signer: _____

Date: _____

Department Review

Project Officer Name:

Department:

Signature: _____ Date: _____

EXHIBIT D.1: REIMBURSEMENT INSTRUCTIONS

Reimbursement by COUNTY will be within 30 days of receipt of acceptable countersigned itemized invoices or billings reflecting the actual cost to SUBRECIPIENT of eligible expenses. Each invoice shall be accompanied with a detailed Request for Reimbursement (Exhibit D) which shall include appropriate documentation. This documentation shall include signed and approved timecards for personnel expenses and itemized invoices or billings for materials and services.

- COUNTY must provide HUD with specific household demographic information for each household served by CDBG funds. The household information will be collected from SUBRECIPIENT and must accompany the first SUBRECIPIENT invoice for each household.
- The request for reimbursement shall also include a summary of expenses incurred for each household along with source documentation. In addition, an HMIS report documenting the type and amount of financial assistance for each household shall accompany the invoice.
- Information on the request for reimbursement form, the household demographics, the source documentation and the summary of expenses incurred for each specific household from the HMIS reports must all correlate. See Attachment A.

Project Name: CDBG 2021 Children's Programming	***Agreement #: 22-018***
Federal Award #: B21-UC-41-0001	***Date of Submission: XX/XX/XX***
Subrecipient: CLACKAMAS WOMEN'S SERVICES	
Has Subrecipient submitted all requests for reimbursement? Y/N	
Has Subrecipient met all programmatic closeout requirements? Y/N	

EXHIBIT E: Final Financial Report

Report of Funds received, expended, and reported as match (if applicable) under this agreement

Total Federal Funds authorized on this agreement:	$15,000
Year-to-Date Federal Funds requested for reimbursement on this agreement:	
Total Federal Funds received on this agreement:	
Balance of unexpended Federal Funds (Line 1 minus Line 3):	

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

Subrecipient's Certifying Official (printed): _____

Subrecipient's Certifying Official (signature): _____

Subrecipient's Certifying Official's title: _____

ATTACHMENT A

COMMUNITY DEVELOPMENT BLOCK GRANT ANNUAL PERFORMANCE REPORT
FOR THE PERIOD: JULY 1, _____ TO JUNE 30, _____ (after project completion)

Project Name: **CWS Children's Programming**

Total Number Assisted (H or P)	Total of Columns C, D, and E	Income Categories			Female Headed Households
		Low/Mod (80% - 51%)	Very Low (50% - 30%)	Extremely Low (<30%)	
(A)	(B)	(C)	(D)	(E)	(F)

# of Females_____
# of Males _____
# of Elderly_____
# of persons with disabilities_____

Race Categories			
		Total #	# Hispanic
		(G)	(H)
(1)	White:		
(2)	Black/African American:		
(3)	Asian:		
(4)	American Indian/Alaskan Native:		
(5)	Native Hawaiian/Other Pacific Islander:		
(6)	American Indian/Alaskan Native & White:		
(7)	Asian & White:		
(8)	Black/African American & White:		
(9)	Am.Indian/Alaskan Native & Black/African Am:		
(10)	Other Multi-Racial:		

_____ _____
Signature Date

_____
Organization

INSTRUCTIONS

Total Number Assisted (Column A):

Enter the actual number of persons (or households) who received assistance. Indicate whether this number represents "households" or "persons" with either (H) or (P) respectively. Each household or person may be counted only once. The number of beneficiaries reported in Column A must reflect the total of the beneficiaries reported in Column G.

Total Low/Mod (<80% MFI) (Column B):

The total number of lower income households or persons being served (total of Columns C, D, and E) should be entered in this column.

Income Categories

Low/Mod (Column C) - The total number of persons or households assisted who have an annual household income of 51% to 80% Median Family Income.

Low (Column D) - The total number of persons or households assisted who have an annual household income of 30% to 50% Median Family Income.

Extremely Low (Column E) - The total number of persons or households assisted who have an annual household income of 30% Median Family Income or less.

Female-Headed Household (Column F)

Enter the number of female-headed households. If "persons" assisted is reported in Column A rather than "households" assisted, leave this column blank.

Race (Rows 1 through 10)

All persons/households served (including persons of Hispanic ethnicity) must indicate Race.

Enter the number of households or persons using the facility or service (Column G) who are the following:

White (Row 1) - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. This category will generally include persons of Hispanic ethnicity but other categories may be chosen as appropriate.

Black or African American (Row 2) - A person having origins in any of the black racial groups of Africa.

Asian (Row 3) - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.

American Indian or Alaskan Native Origin (Row 4) - A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliations or community recognition.

Native Hawaiian or Other Pacific Islander (Row 5) – A person having origins in the Hawaiian Islands or other Pacific Islands.

American Indian or Alaska Native **and** White (Row 6)

Asian **and** White (Row 7)

Black or African American **and** White (Row 8)

American Indian or Alaska Native **and** Black or African American (Row 9)

Other Multi-Racial (Row 10) – The balance category will be used to report individuals that are not included in any of the single race categories or in any of the multiple race categories listed above.

Ethnicity – Hispanic (Column H)
Enter the total number of persons or households within each Race Category who indicate origins in Mexico, Puerto Rico, Cuba, Central or South America or other Spanish culture or origin.

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Members of the Board:

Approval of Subordination Agreement with JLL Real Estate Capital, LLC for HOME Loan with Mt. Scott Terrace and attached Legal Counsel Board Order Approving Agreement provided there are no material changes. Subordination is to agree to JLL Real Estate Capital, LLC in first position, for a loan term of 7 years.

No County General Funds, changes in HOME requirements, or HOME funding are involved.

Purpose/Outcome	Request approval of subordination request from Guardian Holding, Inc. for the refinancing of HOME loan activity – Mt. Scott Terrace Limited Partnership with JLL Real Estate Capital, LLC and attached Legal Counsel Board Order.
Dollar Amount and Fiscal Impact	No fiscal impact
Funding Source	HUD HOME 2004 affordable housing activity. No County General Funds are involved.
Duration	Effective upon signature until May 31, 2036.
Previous Board Action/Review	BCC Business meetings – May 27, 2004, HOME loan documents approved in the amount of $400,000 for 9 HOME units; April 28, 2005, Amendment #1 approved to increase funding to $450,000 for 10 HOME units; August 5, 2021, Transfer of General Partner interests from Geller, Silvis & Associates, Inc. to Guardian Holding, Inc.
Strategic Plan Alignment	Approval of this item will allow for continued access to safe, stable, affordable housing for fifty-two households with incomes below 60% of median area income; and build public trust by sharing the process to date in this request for BCC approval.
Counsel Review	Date of County Counsel review: November 1, 2021 County Counsel: Andrew Naylor * requesting attached Board Order approval for requested Subordination document, explanation in Background section
Procurement Review	Was the item process through Procurement? *yes* ☐ *no X* If no, provide brief explanation: item is not procuring goods or services
Contact Person	Pamela Anderson 971/804-3464
Contract No.	10420

BACKGROUND:

History - Clackamas County entered into a HOME loan Agreement with Mt. Scott Associates Limited Partnership dated Mary 27, 2004, as subsequently amended April 28, 2005, in the amount of $450,000 for the development of the Mt. Scott Terrace, a multi-family rental project consisting of 52, two and three bedroom units targeting working families located in Happy Valley, OR.

On August 5, 2021 the BCC approved the transfer from Anna's Geller Properties LLC entity to Guardian GM Mt. Scott Terrace LLC.

Guardian entity is acquiring the limited partner interests with a re-finance with JLL Real Estate Capital, LLC (Lender). JLL Real Estate Capital, LLC is requesting that the HOME loan be subordinate to their loan. The loan closing with them will be after this BCC meeting and is dependent on BCC approval.

County Counsel, Andrew Naylor, has reviewed the Subordination document and has provided approval with the attached prepared Board Order for Clackamas County Board of Commissioners or County Administrator. This prepared Board Order delegate's limited authority to sign the Agreement provided no material changes are made between the date of this Order and the closing of Borrower's refinance transaction due to BCC meeting and loan closing timing differences. The Freddie Mac subordination agreement will not be signed by the parties until much closer to closing as is Freddie Mac's standard, nationwide practice.

Guardian entity will continue to own and operate the property abiding by all HOME requirements in the original HOME loan documents.

RECOMMENDATION:

Staff recommends approval of both the Subordination request and the County Counsel prepared Board Order, and authorizes the Chair/County Administrator to sign on behalf of the County.

Respectfully submitted,

Mary Rumbaugh

Rodney A. Cook
Director
Health, Housing and Human Services (H3S)

Contract Transmittal Form

Health, Housing & Human Services Department

H3S Contract #: 10420

Board Order #:

Division: CD
Contact: Anderson, Pamela
Program Contact:
Anderson, Pamela

☐ **Subrecipient**
☐ **Revenue**
☐ **Amend #** **$**
☐ **Procurement Verified**
☐ **Aggregate Total Verified**

☐ ***Non BCC Item*** ☑ ***BCC Agenda*** ***Date:*** Wednesday, November 24, 2021

CONTRACT WITH: **Mt. Scott Associates Limited Partnership**

CONTRACT AMOUNT: $450,000.00

TYPE OF CONTRACT

☐ **Agency Service Contract**
☐ **Construction Agreement**
☐ **Intergovernmental Agreement**
☐ **Interagency Services Agreement**
☐ **Memo of Understanding/Agreement**
☐ **Professional, Technical & Personal Services**
☐ **Property/Rental/Lease**
☑ **One Off**

DATE RANGE

☐ **Full Fiscal Year** _____ - _____
☑ **Upon Signature** _____ - _____
☐ **Other** _____ - _____
☐ **4 or 5 Year** _____ - _____
☐ **Biennium** _____ - _____
☐ **Retroactive Request?** _____ - _____

INSURANCE What insurance language is required?

☐ Checked Off ☑ N/A

Commercial General Liability: ☐ Yes ☐ No, not applicable ☐ No, waived
If no, explain why:

Business Automobile Liability: ☐ Yes ☐ No, not applicable ☐ No, waived
If no, explain why:

Professional Liability: ☐ Yes ☐ No, not applicable ☐ No, waived
If no, explain why:

Approved by Risk Mgr _____
Risk Mgr's Initials and Date

BOILER PLATE CHANGE

Has contract boilerplate language been altered, added, or deleted?

☑ No ☐ Yes (must have CC approval-next box) ☐ N/A (Not a County boilerplate - must have CC approval)

If yes, what language has been altered, added, or deleted and why: _____

COUNTY COUNSEL

☐ Yes by: Andrew Naylor Date Approved: Monday, November 1, 2021

OR

☐ This contract is in the format approved by County Counsel.

SIGNATURE OF DIVISION REPRESENTATIVE: Pamela Anderson

Date: Nov. 3, 2021

H3S Admin Only
Date Received: _____
Date Signed: _____
Date Sent: _____

AGREEMENTS/CONTRACTS

New Agreement/Contract

X Amendment/Change Order Original Number_____

ORIGINATING COUNTY DEPARTMENT: **Health, Housing Human Services Community Development**

PURCHASING FOR: **Contracted Services**

OTHER PARTY TO CONTRACT/AGREEMENT: **Mt. Scott Associates Limited Partnership**

BOARD AGENDA ITEM NUMBER/DATE: **DATE:** **11/24/2021**

PURPOSE OF CONTRACT/AGREEMENT: A multi-family rental project consisting of 52, two and three bedroom units targeting working families located in Happy Valley, OR.

Guardian entity is acquiring the limited partner interests with a re-finance with JLL Real Estate Capital, LLC (Lender) for Mt. Scott Terrace 2004 HOME affordable housing acticity. JLL Real Estate Capital, LLC is requesting that the HOME loan be subordinate to their loan. Subordination and Legal Counsel Board Order documents being submitted for BCC approval for this item.

H3S CONTRACT NUMBER: **10420**

Prepared by, and after recording
return to:
Robinson & Cole LLP
1055 Washington Boulevard
Stamford, CT 06901
Attention: Matthew M. Dolan, Esq.

Property Name: Terrace at Mount Scott Apartments
Freddie Mac Loan Number: 508841208

SUBORDINATION AGREEMENT

GOVERNMENTAL ENTITY

(Revised 6-15-2020)

Property Name: Terrace at Mount Scott Apartments
Freddie Mac Loan Number: 508841208

SUBORDINATION AGREEMENT

GOVERNMENTAL ENTITY

(Revised 6-15-2020)

THIS SUBORDINATION AGREEMENT ("**Agreement**") is entered into as of October __, 2021, by and between (i) **JLL REAL ESTATE CAPITAL, LLC**, a Delaware limited liability company ("**Senior Lender**") and (ii) **CLACKAMAS COUNTY**, a political subdivision of the State of Oregon, through its Community Development Division ("**Subordinate Lender**").

RECITALS

A. MT. SCOTT ASSOCIATES LIMITED PARTNERSHIP, an Oregon limited partnership (**"Borrower"**) is the owner of certain land located in Clackamas County, Oregon, described in Exhibit A ("**Land**"). The Land is improved with a multifamily rental housing project ("**Improvements**").

B. Senior Lender has made or is making a loan to Borrower in the original principal amount of $4,010,000 ("**Senior Loan**") upon the terms and conditions of a Multifamily Loan and Security Agreement dated as of October __, 2021, between Senior Lender and Borrower ("**Senior Loan Agreement**") in connection with the Mortgaged Property. The Senior Loan is secured by a Multifamily Deed of Trust, Assignment of Rents and Security Agreement dated as of the date of the Senior Loan Agreement ("**Senior Mortgage**") encumbering the Land, the Improvements and related personal and other property described and defined in the Senior Mortgage as the "**Mortgaged Property**."

C. Pursuant to a HOME Loan Agreement dated as of May 27, 2004, between Subordinate Lender and Borrower, as amended ("**Subordinate Loan Agreement**"), Subordinate Lender has made or is making a loan to Borrower in the original principal amount of $400,000, as increased to $450,000 ("**Subordinate Loan**"). The Subordinate Loan is or will be secured by a Trust Deed, Assignment of Rents, Security Agreement and Fixture Filing dated as of September 2, 2004, as amended ("**Subordinate Mortgage**") encumbering all or a portion of the Mortgaged Property.

D. The Senior Mortgage will be recorded in the Official Records of Clackamas County, Oregon ("**Recording Office**"). The Subordinate Mortgage is recorded in the Recording Office at as Document Number 2004-082774, as modified by Document Number 2005-43650.

E. The execution and delivery of this Agreement is a condition of Senior Lender's making of the Senior Loan.

AGREEMENT

NOW, THEREFORE, for valuable consideration, the receipt and sufficiency of which is acknowledged, the parties agree as follows:

1. Definitions. The following terms, when used in this Agreement (including, as appropriate, when used in the above recitals), will have the following meanings:

The terms "**Condemnation**," "**Imposition Deposits**," "**Impositions**," "**Leases,**" "**Rents**" and "**Restoration**," as well as any term used in this Agreement and not otherwise defined in this Agreement, will have the meanings given to those terms in the Senior Loan Agreement.

"**Bankruptcy Proceeding**" means any bankruptcy, reorganization, insolvency, composition, restructuring, dissolution, liquidation, receivership, assignment for the benefit of creditors, or custodianship action or proceeding under any federal or state law with respect to Borrower, any guarantor of any of the Senior Indebtedness, any of their respective properties, or any of their respective partners, members, officers, directors, or shareholders.

"**Borrower**" means all persons or entities identified as "Borrower" in the first Recital of this Agreement, together with their successors and assigns, and any other person or entity who acquires title to the Mortgaged Property after the date of this Agreement; provided that the term "Borrower" will not include Senior Lender if Senior Lender acquires title to the Mortgaged Property.

"**Casualty**" means the occurrence of damage to or loss of all or any portion of the Mortgaged Property by fire or other casualty.

"**Enforcement Action**" means any of the following actions taken by or at the direction of Subordinate Lender: the acceleration of all or any part of the Subordinate Indebtedness, the advertising of or commencement of any foreclosure or trustee's sale proceedings, the exercise of any power of sale, the acceptance of a deed or assignment in lieu of foreclosure or sale, the collecting of Rents, the obtaining of or seeking of the appointment of a receiver, the seeking of default interest, the taking of possession or control of any of the Mortgaged Property, the commencement of any suit or other legal, administrative, or arbitration proceeding based upon the Subordinate Note or any other of the Subordinate Loan Documents, the exercising of any banker's lien or rights of set-off or recoupment, or the exercise of any other remedial action against Borrower, any other party liable for any of the Subordinate Indebtedness or obligated under any of the Subordinate Loan Documents, or the Mortgaged Property.

"**Enforcement Action Notice**" means a Notice given from Subordinate Lender to Senior Lender following one or more Subordinate Mortgage Default(s) and the expiration of any applicable notice or cure periods, setting forth in reasonable detail the Subordinate Mortgage Default(s) and the Enforcement Actions proposed to be taken by Subordinate Lender.

"**Lien**" means any lien, encumbrance, estate or other interest, recorded against or secured by the Mortgaged Property.

"**Loss Proceeds**" means all monies received or to be received under any insurance policy, from any condemning authority, or from any other source, as a result of any Condemnation or Casualty.

"**Notice**" means all notices, requests, demands, consents, approvals or other communication pursuant to this Agreement provided in accordance with the provisions of Section 10.

"**Regulatory Agreement**" means the Declaration of Land Use Restrictive Covenants between Borrower and Subordinate Lender recorded in the Recording Office on September 3, 2004 as Recording No.: 2004-082773; which Declaration was modified and replaced by instrument recorded May 13, 2005 as Recording No.: 2005-043649; which Declaration was further modified and replaced by instrument recorded January 17, 2007 as Recording No.: 2007-003798; and as amended by instrument recorded October 23, 2015, as Recording No.: 2015-071424.

"**Senior Indebtedness**" means the "Indebtedness" as defined in the Senior Loan Agreement.

"**Senior Lender**" means the "Lender" as defined in the Senior Mortgage. When any other person or entity becomes the legal holder of the Senior Note, such other person or entity will automatically become Senior Lender.

"**Senior Loan Documents**" means the "Loan Documents" as defined in the Senior Loan Agreement, as such documents may be amended.

"**Senior Mortgage Default**" means any act, failure to act, event, condition, or occurrence which constitutes, or which with the giving of Notice or the passage of time, or both, would constitute, an "Event of Default" as defined in the Senior Loan Agreement.

"**Senior Note**" means the promissory note or other evidence of the Senior Indebtedness and any replacement of the Senior Note.

"**Subordinate Indebtedness**" means all sums evidenced or secured or guaranteed by, or otherwise due and payable to Subordinate Lender pursuant to, the Subordinate Loan Documents.

"**Subordinate Lender**" means the person or entity named as such in the first paragraph of this Agreement and any other person or entity who becomes the legal holder of the Subordinate Note after the date of this Agreement.

"**Subordinate Loan Documents**" means the Subordinate Mortgage, the Subordinate Note, the Subordinate Loan Agreement, the Regulatory Agreement and all other documents at any time evidencing, securing, guaranteeing, or otherwise delivered in connection with the Subordinate Indebtedness, as such documents may be amended.

"**Subordinate Mortgage Default**" means any act, failure to act, event, condition, or occurrence which allows (but for any contrary provision of this Agreement), Subordinate Lender to take an Enforcement Action.

"**Subordinate Note**" means the promissory note or other evidence of the Subordinate Indebtedness and any replacement of the Subordinate Note.

"**Surplus Cash**" means, with respect to any period, any revenues of Borrower remaining after paying, or setting aside funds for paying, all the following:

(a) All sums due or currently required to be paid under the Senior Loan Documents, including any reserves and Imposition Deposits.

(b) All reasonable operating expenses of the Mortgaged Property, including real estate taxes, insurance premiums, utilities, building maintenance, painting and repairs, management fees, payroll, administrative expenses, legal expenses and audit expenses (excluding any developer fees payable with respect to the Mortgaged Property).

2. Subordinate Lender's Representations and Warranties.

(a) Subordinate Lender represents and warrants that each of the following is true as of the date of this Agreement:

(i) Subordinate Lender is now the owner and holder of the Subordinate Loan Documents.

(ii) No Subordinate Mortgage Default has occurred and is continuing.

(iii) The current unpaid principal balance of the Subordinate Indebtedness is [$_____].

(iv) No scheduled payments under the Subordinate Note have been prepaid.

(b) Without the prior written consent of Senior Lender, Subordinate Lender will not do any of the following:

(i) Pledge, assign, transfer, convey, or sell any interest in the Subordinate Indebtedness or any of the Subordinate Loan Documents.

(ii) Take any action which has the effect of increasing the Subordinate Indebtedness, except to cure a Senior Mortgage Default as contemplated under Section 5(a) of this Agreement.

(iii) Accept any prepayment of the Subordinate Indebtedness.

3. Terms of Subordination.

(a) Agreement to Subordinate. The Subordinate Indebtedness is and will at all times continue to be subject and subordinate in right of payment to the prior payment in full of the Senior Indebtedness. Each of the Subordinate Loan Documents is, and will at all times remain, subject and subordinate in all respects to the liens, terms, covenants, conditions, operations, and effects of each of the Senior Loan Documents.

(b) Subordination of Subrogation Rights. If Subordinate Lender, by indemnification, subrogation or otherwise, acquires any Lien on any of the Mortgaged Property, then that Lien will be fully subject and subordinate to the receipt by Senior Lender of payment in full of the Senior Indebtedness, and to the Senior Loan Documents, to the same extent as the Subordinate Indebtedness and the Subordinate Loan Documents are subordinate pursuant to this Agreement.

(c) Payments Before Senior Loan Default; Soft Subordinate Debt. Until the occurrence of a Senior Mortgage Default, Subordinate Lender will be entitled to retain for its own account all payments of the principal of and interest on the Subordinate Indebtedness pursuant to the Subordinate Loan Documents; provided that Subordinate Lender expressly agrees that it will not accept any such payment that is made more than 10 days in advance of its due date and provided further that Subordinate Lender agrees that Borrower will not be obligated to make payments on the Subordinate Indebtedness in an amount that exceeds 75% of then available Surplus Cash.

(d) Payments After Senior Loan Default or Bankruptcy.

(i) Immediately upon Subordinate Lender's receipt of Notice or actual knowledge of a Senior Mortgage Default, Subordinate Lender will not accept any payments of the Subordinate Indebtedness, and the provisions of Section 3(d) of this Agreement will apply.

(ii) If Subordinate Lender receives any of the following, whether voluntarily or by action of law, after a Senior Mortgage Default of which Subordinate Lender has actual knowledge (or is deemed to have actual knowledge as

provided in Section 4(c)) or has been given Notice, such will be received and held in trust for Senior Lender:

(A) Any payment, property, or asset of any kind or in any form in connection with the Subordinate Indebtedness.

(B) Any proceeds from any Enforcement Action.

(C) Any payment, property, or asset in or in connection with any Bankruptcy Proceeding.

(iii) Subordinate Lender will promptly remit, in kind and properly endorsed as necessary, all such payments, properties, and assets described in Section 3(d)(ii) to Senior Lender. Senior Lender will apply any payment, asset, or property so received from Subordinate Lender to the Senior Indebtedness in such order, amount (with respect to any asset or property other than immediately available funds), and manner as Senior Lender determines in its sole and absolute discretion.

(e) Bankruptcy. Without the prior written consent of Senior Lender, Subordinate Lender will not commence, or join with any other creditor in commencing, any Bankruptcy Proceeding. In the event of a Bankruptcy Proceeding, Subordinate Lender will not vote affirmatively in favor of any plan of reorganization or liquidation unless Senior Lender has also voted affirmatively in favor of such plan.

4. Default Under Subordinate Loan Documents.

(a) Notice of Subordinate Loan Default and Cure Rights.

(i) Subordinate Lender will deliver to Senior Lender a copy of each Notice delivered by Subordinate Lender pursuant to the Subordinate Loan Documents within 5 Business Days of sending such Notice to Borrower. Neither giving nor failing to give a Notice to Senior Lender pursuant to this Section 4(a) will affect the validity of any Notice given by Subordinate Lender to Borrower.

(ii) For a period of 90 days following delivery to Senior Lender of an Enforcement Action Notice, Senior Lender will have the right, but not the obligation, to cure any Subordinate Mortgage Default. However, if such Subordinate Mortgage Default is a non-monetary default and is not capable of being cured within such 90-day period and Senior Lender has commenced and is diligently pursuing such cure to completion, Senior Lender will have such additional period of time as may be required to cure such Subordinate Mortgage Default or until such time, if ever, as Senior Lender takes either of the following actions:

(A) Discontinues its pursuit of any cure.

(B) Delivers to Subordinate Lender Senior Lender's written consent to the Enforcement Action described in the Enforcement Action Notice.

(iii) Senior Lender will not be subrogated to the rights of Subordinate Lender under the Subordinate Loan Documents as a result of Senior Lender having cured any Subordinate Mortgage Default.

(iv) Subordinate Lender acknowledges that all amounts advanced or expended by Senior Lender in accordance with the Senior Loan Documents or to cure a Subordinate Mortgage Default will be added to and become a part of the Senior Indebtedness and will be secured by the lien of the Senior Mortgage.

(b) Subordinate Lender's Exercise of Remedies After Notice to Senior Lender.

(i) In the event of a Subordinate Mortgage Default, Subordinate Lender will not commence any Enforcement Action until 90 days after Subordinate Lender has delivered to Senior Lender an Enforcement Action Notice. During such 90-day period or such longer period as provided in Section 4(a), Subordinate Lender will be entitled to seek specific performance to enforce covenants and agreements of Borrower relating to income, rent, or affordability restrictions contained in the Regulatory Agreement, subject to Senior Lender's right to cure a Subordinate Mortgage Default set forth in Section 4(a).

(ii) Subordinate Lender may not commence any other Enforcement Action, including any foreclosure action under the Subordinate Loan Documents, until the earlier of:

(A) The expiration of such 90-day period or such longer period as provided in Section 4(a).

(B) The delivery by Senior Lender to Subordinate Lender of Senior Lender's written consent to such Enforcement Action by Subordinate Lender.

(iii) Subordinate Lender acknowledges that Senior Lender may grant or refuse consent to Subordinate Lender's Enforcement Action in Senior Lender's sole and absolute discretion. At the expiration of such 90-day period or such longer period as provided in Section 4(a) and, subject to Senior Lender's right to cure set forth in Section 4(a), Subordinate Lender may commence any Enforcement Action.

(iv) Senior Lender may pursue all rights and remedies available to it under the Senior Loan Documents, at law, or in equity, regardless of any Enforcement Action Notice or Enforcement Action by Subordinate Lender. No action or failure to act on the part of Senior Lender in the event of a Subordinate Mortgage Default or commencement of an Enforcement Action will constitute a waiver on the part of Senior Lender of any provision of the Senior Loan Documents or this Agreement.

(c) Cross Default. Subordinate Lender acknowledges that a Subordinate Mortgage Default constitutes a Senior Mortgage Default. Accordingly, upon the occurrence of a Subordinate Mortgage Default, Subordinate Lender will be deemed to have actual knowledge of a Senior Mortgage Default. If Subordinate Lender notifies Senior Lender in writing that any Subordinate Loan Default of which Senior Lender has received Notice has been cured or waived, as determined by Subordinate Lender in its sole discretion, then provided that Senior Lender has not conducted a sale of the Mortgaged Property pursuant to its rights under the Senior Loan Documents, any Senior Loan Default under the Senior Loan Documents arising solely from such Subordinate Loan Default will be deemed cured, and the Senior Loan will be reinstated.

5. Default Under Senior Loan Documents.

(a) Notice of Senior Loan Default and Cure Rights.

(i) Senior Lender will deliver to Subordinate Lender a copy of any Notice sent by Senior Lender to Borrower of a Senior Mortgage Default within 5 Business Days of sending such Notice to Borrower. Failure of Senior Lender to send Notice to Subordinate Lender will not prevent the exercise of Senior Lender's rights and remedies under the Senior Loan Documents.

(ii) Subordinate Lender will have the right, but not the obligation, to cure any monetary Senior Mortgage Default within 30 days following the date of such Notice. During such 30-day period Senior Lender will be entitled to continue to pursue its remedies under the Senior Loan Documents.

(iii) Subordinate Lender may, within 90 days after the date of the Notice, cure a non-monetary Senior Mortgage Default if during such 90-day period, Subordinate Lender keeps current all payments required under the Senior Loan Documents. If such a non-monetary Senior Mortgage Default creates an unacceptable level of risk relative to the Mortgaged Property, or Senior Lender's secured position relative to the Mortgaged Property, as determined by Senior Lender in its sole discretion, then during such 90-day period Senior Lender may exercise all available rights and remedies to protect and preserve the Mortgaged Property and the Rents, revenues and other proceeds from the Mortgaged Property.

(iv) All amounts paid by Subordinate Lender to Senior Lender to cure a Senior Mortgage Default will be deemed to have been advanced by Subordinate Lender pursuant to, and will be secured by the lien of, the Subordinate Mortgage. Notwithstanding anything in this Section 5(a) to the contrary, Subordinate Lender's right to cure any Senior Mortgage Default will terminate immediately upon the occurrence of any Bankruptcy Proceeding.

(b) Release of Mortgaged Property.

(i) Subordinate Lender consents to and authorizes any future release by Senior Lender of all or any portion of the Mortgaged Property from the lien, operation, and effect of the Senior Loan Documents. Subordinate Lender waives to the fullest extent permitted by law, all equitable or other rights it may have in connection with the release of all or any portion of the Mortgaged Property, including any right to require Senior Lender to do any of the following:

(A) To conduct a separate sale of any portion of the Mortgaged Property.

(B) To exhaust its remedies against all or any portion of the Mortgaged Property or any combination of portions of the Mortgaged Property or any other collateral for the Senior Indebtedness.

(C) To proceed against Borrower, any other party that may be liable for any of the Senior Indebtedness (including any general partner of Borrower if Borrower is a partnership), all or any portion of the Mortgaged Property or combination of portions of the Mortgaged Property or any other collateral, before proceeding against all or such portions or combination of portions of the Mortgaged Property as Senior Lender determines.

(ii) Subordinate Lender consents to and authorizes, at the option of Senior Lender, the sale, either separately or together, of all or any portion of the Mortgaged Property. Subordinate Lender acknowledges that without Notice to Subordinate Lender and without affecting any of the provisions of this Agreement, Senior Lender may do any of the following:

(A) Extend the time for or waive any payment or performance under the Senior Loan Documents.

(B) Modify or amend in any respect any provision of the Senior Loan Documents.

(C) Modify, exchange, surrender, release, and otherwise deal with any additional collateral for the Senior Indebtedness.

6. **Conflicts.** If there is any conflict or inconsistency between the terms of the Subordinate Loan Documents and the terms of this Agreement, then the terms of this Agreement will control. Borrower acknowledges that the terms and provisions of this Agreement will not, and will not be deemed to do any of the following:

(a) Extend Borrower's time to cure any Senior Loan Default or Subordinate Loan Default.

(b) Give Borrower the right to receive notice of any Senior Loan Default or Subordinate Loan Default, other than that, if any, provided, respectively under the Senior Loan Documents of the Subordinate Loan Documents.

(c) Create any other right or benefit for Borrower as against Senior Lender or Subordinate Lender.

7. **Rights and Obligations of Subordinate Lender Under the Subordinate Loan Documents and of Senior Lender under the Senior Loan Documents.**

(a) Insurance.

(i) All requirements pertaining to insurance under the Subordinate Loan Documents (including requirements relating to amounts and types of coverages, deductibles and special endorsements) will be deemed satisfied if Borrower complies with the insurance requirements under the Senior Loan Documents and of Senior Lender.

(ii) All original policies of insurance required pursuant to the Senior Loan Documents will be held by Senior Lender.

(iii) Nothing in this Section 7(a) will preclude Subordinate Lender from requiring that it be named as a mortgagee and loss payee, as its interest may appear, under all policies of property damage insurance maintained by Borrower with respect to the Mortgaged Property, provided such action does not affect the priority of payment of Loss Proceeds, or that Subordinate Lender be named as an additional insured under all policies of liability insurance maintained by Borrower with respect to the Mortgaged Property.

(b) Condemnation or Casualty.

In the event of a Condemnation or a Casualty, the following provisions will apply:

(i) The rights of Subordinate Lender (under the Subordinate Loan Documents or otherwise) to participate in any proceeding or action relating to a Condemnation or a Casualty, or to participate or join in any settlement of,

or to adjust, any claims resulting from a Condemnation or a Casualty, will be and remain subordinate in all respects to Senior Lender's rights under the Senior Loan Documents, and Subordinate Lender will be bound by any settlement or adjustment of a claim resulting from a Condemnation or a Casualty made by Senior Lender.

(ii) All Loss Proceeds will be applied either to payment of the costs and expenses of Restoration or to payment on account of the Senior Indebtedness, as and in the manner determined by Senior Lender in its sole discretion; provided however, Senior Lender agrees to consult with Subordinate Lender in determining the application of Casualty proceeds. In the event of any disagreement between Senior Lender and Subordinate Lender over the application of Casualty proceeds, the decision of Senior Lender, in its sole discretion, will prevail.

(iii) If Senior Lender holds Loss Proceeds, or monitors the disbursement of Loss Proceeds, Subordinate Lender will not do so. Nothing contained in this Agreement will be deemed to require Senior Lender to act for or on behalf of Subordinate Lender in connection with any Restoration or to hold or monitor any Loss Proceeds in trust for or otherwise on behalf of Subordinate Lender, and all or any Loss Proceeds may be commingled with any funds of Senior Lender.

(iv) If Senior Lender elects to apply Loss Proceeds to payment on account of the Senior Indebtedness, and if the application of such Loss Proceeds results in the payment in full of the entire Senior Indebtedness, any remaining Loss Proceeds held by Senior Lender will be paid to Subordinate Lender unless another party has asserted a claim to the remaining Loss Proceeds.

(c) Modification of Subordinate Loan Documents. Subordinate Lender agrees that, until the principal of, interest on and all other amounts payable under the Senior Loan Documents have been paid in full, it will not, without the prior written consent of Senior Lender, increase the amount of the Subordinate Loan, increase the required payments due under the Subordinate Loan, decrease the term of the Subordinate Loan, increase the interest rate on the Subordinate Loan, or otherwise amend the Subordinate Loan terms in a manner that creates an adverse effect upon Senior Lender under the Senior Loan Documents. If Subordinate Lender either (i) amends the Subordinate Loan Documents in the manner set forth above or (ii) assigns the Subordinate Loan without Senior Lender's consent then such amendment or assignment will be void ab initio and of no effect whatsoever.

(d) Modification of Senior Loan Documents. Senior Lender may amend, waive, postpone, extend, renew, replace, reduce or otherwise modify any provisions of the Senior Loan Documents without the necessity of obtaining the consent of or providing Notice to Subordinate Lender, and without affecting any of the

provisions of this Agreement. Notwithstanding the foregoing, Senior Lender may not modify any provision of the Senior Loan Documents that increases the Senior Indebtedness, except for increases in the Senior Indebtedness that result from advances made by Senior Lender to protect the security or lien priority of Senior Lender under the Senior Loan Documents or to cure defaults under the Subordinate Loan Documents.

(e) Commercial or Retail Leases. If requested, Subordinate Lender will enter into attornment and non-disturbance agreements with all tenants under commercial or retail Leases, if any, to whom Senior Lender has granted attornment and non-disturbance, on the same terms and conditions given by Senior Lender.

(f) Consent Rights. Whenever the Subordinate Loan Documents give Subordinate Lender approval or consent rights with respect to any matter, and a right of approval or consent for the same or substantially the same matter is also granted to Senior Lender pursuant to the Senior Loan Documents or otherwise, Senior Lender's approval or consent or failure to approve or consent will be binding on Subordinate Lender. None of the other provisions of Section 7 are intended to be in any way in limitation of the provisions of this Section 7(f).

(g) Escrows. Except as provided in this Section 7(g), and regardless of any contrary provision in the Subordinate Loan Documents, Subordinate Lender will not collect any escrows for any cost or expense related to the Mortgaged Property or for any portion of the Subordinate Indebtedness. However, if Senior Lender is not collecting escrow payments for one or more Impositions, Subordinate Lender may collect escrow payments for such Impositions; provided that all payments so collected by Subordinate Lender will be held in trust by Subordinate Lender to be applied only to the payment of such Impositions.

(h) Certification. Within 10 days after request by Senior Lender, Subordinate Lender will furnish Senior Lender with a statement, duly acknowledged and certified setting forth the then-current amount and terms of the Subordinate Indebtedness, confirming that there exists no default under the Subordinate Loan Documents (or describing any default that does exist), and certifying to such other information with respect to the Subordinate Indebtedness as Senior Lender may request.

8. Refinancing. Subordinate Lender agrees that its agreement to subordinate under this Agreement will extend to any new mortgage debt which is for the purpose of refinancing all or any part of the Senior Indebtedness (including reasonable and necessary costs associated with the closing and/or the refinancing, and any reasonable increase in proceeds for rehabilitation in the context of a preservation transaction). All terms and covenants of this Agreement will inure to the benefit of any holder of any such refinanced debt, and all references to the Senior Loan Documents and Senior Lender will mean, respectively, the refinance loan documents and the holder of such refinanced debt.

9. **Governmental Powers.** Nothing in this Agreement is intended, nor will it be construed, to in any way limit the exercise by Subordinate Lender of its governmental powers (including police, regulatory and taxing powers) with respect to Borrower or the Mortgaged Property to the same extent as if it were not a party to this Agreement or the transactions contemplated by this Agreement.

10. **Notices.**

(a) Any Notice required or permitted to be given pursuant to this Agreement will be in writing and will be deemed to have been duly and sufficiently given if (i) personally delivered with proof of delivery (any Notice so delivered will be deemed to have been received at the time so delivered), or (ii) sent by a national overnight courier service (such as FedEx) designating earliest available delivery (any Notice so delivered will be deemed to have been received on the next Business Day following receipt by the courier), or (iii) sent by United States registered or certified mail, return receipt requested, postage prepaid, at a post office regularly maintained by the United States Postal Service (any Notice so sent will be deemed to have been received on the date of delivery as confirmed by the return receipt), addressed to the respective parties as follows:

Notices intended for Senior Lender will be addressed to:

JLL Real Estate Capital, LLC
2177 Youngman Avenue
St. Paul, Minnesota 55116
Attn: Loan Servicing
Email: loanservicing@am.jll.com

Notices intended for Subordinate Lender will be addressed to:

Clackamas County Community Development
2051 Kaen Road
Oregon City, Oregon 97045
Attention: HOME Manager

(b) Any party, by Notice given pursuant to this Section 10, may change the person or persons and/or address or addresses, or designate an additional person or persons or an additional address or addresses, for its Notices, but Notice of a change of address will only be effective upon receipt. Neither party will refuse or reject delivery of any Notice given in accordance with this Section 10.

11. **Miscellaneous Provisions.**

(a) Assignments/Successors. This Agreement will be binding upon and will inure to the benefit of the respective legal successors and permitted assigns of the parties

to this Agreement. No other party will be entitled to any benefits under this Agreement, whether as a third-party beneficiary or otherwise. This Agreement may be assigned at any time by Senior Lender to any subsequent holder of the Senior Note.

(b) No Partnership or Joint Venture. Nothing in this Agreement or in any of the Senior Loan Documents or Subordinate Loan Documents will be deemed to constitute Senior Lender as a joint venturer or partner of Subordinate Lender.

(c) Further Assurances. Upon Notice from Senior Lender, Subordinate Lender will execute and deliver such additional instruments and documents, and will take such actions, as are reasonably required by Senior Lender to further evidence or implement the provisions and intent of this Agreement.

(d) Amendment. This Agreement may be amended, changed, modified, altered or terminated only by a written instrument signed by the parties to this Agreement or their successors or assigns.

(e) Governing Law. This Agreement will be governed by the laws of the State in which the Land is located.

(f) Severable Provisions. If any one or more of the provisions contained in this Agreement, or any application of any such provisions, is invalid, illegal, or unenforceable in any respect, the validity, legality, enforceability, and application of the remaining provisions contained in this Agreement will not in any way be affected or impaired.

(g) Term. The term of this Agreement will commence on the date of this Agreement and will continue until the earliest to occur of the following events:

(i) The payment of all the Senior Indebtedness; provided that this Agreement will be reinstated in the event any payment on account of the Senior Indebtedness is avoided, set aside, rescinded or repaid by Senior Lender.

(ii) The payment of all the Subordinate Indebtedness other than by reason of payments which Subordinate Lender is obligated to remit to Senior Lender pursuant to this Agreement.

(iii) The acquisition by Senior Lender or by a third-party purchaser of title to the Mortgaged Property pursuant to a foreclosure of, deed in lieu of foreclosure, or trustee's sale or other exercise of a power of sale or similar disposition under the Senior Mortgage.

(iv) With the prior written consent of Senior Lender, without limiting the provisions of Section 4(b)(iv), the acquisition by Subordinate Lender of title to the Mortgaged Property subject to the Senior Mortgage pursuant to

a foreclosure, or a deed in lieu of foreclosure, of (or the exercise of a power of sale under) the Subordinate Mortgage.

(h) Counterparts. This Agreement may be executed in two or more counterparts, each of which will be deemed an original but all of which together will constitute one and the same instrument.

(i) Entire Agreement. This Agreement represents the entire understanding and agreement between the parties regarding the matters addressed in this Agreement, and will supersede and cancel any prior agreements regarding such matters.

(j) Authority. Each person executing this Agreement on behalf of a party to this Agreement represents and warrants that such person is duly and validly authorized to do so on behalf of such party with full right and authority to execute this Agreement and to bind such party with respect to all of its obligations under this Agreement.

(k) No Waiver. No failure or delay on the part of any party to this Agreement in exercising any right, power, or remedy under this Agreement will operate as a waiver of such right, power, or remedy, nor will any single or partial exercise of any such right, power or remedy preclude any other or further exercise of such right, power, or remedy or the exercise of any other right, power or remedy under this Agreement.

(l) Remedies. Each party to this Agreement acknowledges that if any party fails to comply with its obligations under this Agreement, the other parties will have all rights available at law and in equity, including the right to obtain specific performance of the obligations of such defaulting party and injunctive relief.

[SIGNATURE AND ACKNOWLEDGMENT PAGES FOLLOW]

IN WITNESS WHEREOF, the parties have duly executed this Agreement as of the day and year first above written.

SENIOR LENDER:

JLL REAL ESTATE CAPITAL, LLC, a Delaware limited liability company

By: _____
Name: Heather L. Cox
Title: Closing Coordinator

STATE OF OHIO)
) ss.:
COUNTY OF DELAWARE)

On the ____ day of _____, 2021, before me, the undersigned, a notary public in and for said state, personally appeared Heather L. Cox, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
Notary Public

SUBORDINATE LENDER:

CLACKAMAS COUNTY, a political subdivision of the State of Oregon, through its Community Development Division

By: _____
Name: _____
Title: _____

STATE OF OREGON)
) ss.:
COUNTY OF CLACKAMAS)

On the ____ day of _____, 2021, before me, the undersigned, a notary public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
Notary Public

CONSENT OF BORROWER

Borrower acknowledges receipt of a copy of this Subordination Agreement, dated October __, 2021, by and between **JLL REAL ESTATE CAPITAL, LLC** and **CLACKAMAS COUNTY** and consents to the agreement of the parties set forth in this Agreement.

BORROWER:

MT. SCOTT ASSOCIATES LIMITED PARTNERSHIP,
an Oregon limited partnership

By: Mt. Scott Terrace, LLC,
an Oregon limited liability company
Its: General Partner

By: GM Mt. Scott Terrace LLC,
an Oregon limited liability company
Its: Manager

By: Guardian Development LLC,
an Oregon limited liability company
Its: Manager

By: Guardian Real Estate Services LLC,
an Oregon limited liability company
Its: Manager

By: Guardian Holding, Inc.,
an Oregon corporation
Its: Manager

By:_____
Name: Thomas Brenneke
Title: President

STATE OF)

) ss.:
COUNTY OF)

On the ____ day of _____, 2021, before me, the undersigned, a notary public in and for said state, personally appeared Thomas Brenneke, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
Notary Public

EXHIBIT A

LEGAL DESCRIPTION

PARCEL I:

The East 20 rods of:

A part of Section 28, Township 1 South, Range 2 East, of the Willamette Meridian, in the County of Clackamas and State of Oregon, more particularly described as:

Beginning at the Southeast corner of Lot 2 of said section, being the Southeast corner of the Samuel W. McMahan Homestead, Notification No. 5746; thence West on the South line of said Lot 2, 40 rods; thence North 40 rods; thence East 40 rods to the quarter section line; thence South 40 rods to the place of beginning.

EXCEPTING THEREFROM a strip of land along the North end of said premises 150 feet in width to be cut off by a line parallel with and 150 feet South of the South line of Otty Road as it existed on September 15, 1999.

ALSO EXCEPTING THEREFROM those portions thereof lying North of the South line of the land conveyed to Clackamas County Development Agency, a political subdivision of the State of Oregon, by Warranty Deed recorded December 23, 1999 as Recorder's Fee No. 99-117404.

ALSO EXCEPTING THEREFROM those portions described by instrument in favor of Clackamas County, recorded February 1, 2011 as Recorder's Fee No. 2011-007382.

ALSO EXCEPTING THEREFROM those portions described by instrument in favor of Clackamas County, recorded May 17, 2011 as Recorder's Fee No. 2011-029478.

PARCEL II:

A part of Section 28, Township 1 South, Range 2 East of the Willamette Meridian, in the County of Clackamas and State of Oregon, described as follows:

Beginning at the Southeast corner of Lot 2 of said section being the Southeast corner of the Samuel W. McMahan Homestead Notification No. 5746; thence West 330.00 feet to a 1/2 inch pipe in the South line of said Lot 2; thence North 485.8 feet to a 1/2 inch pipe which is also the Northwest corner of that certain parcel conveyed by Bertha C. Bohlman to William E. England, et ux. by Deed recorded October 29, 1952 in Book 462, Page 209, Deed Records, and the true place of beginning; thence continuing North 170.00 feet to the center of Otty Road; thence East along the center of Otty Road to an intersection with the center of S.E. 92nd Avenue marked by a 1 inch pipe; thence South 170.00 feet along the center of S.E. 92nd Avenue to the Northeast corner of the said England tract; thence West 330.00 feet to the true place of beginning.

EXCEPTING THEREFROM that portion lying North of the South line of the land conveyed to Clackamas County Development Agency, a political subdivision of the State of Oregon, by Warranty Deed recorded December 23,1999 as Recorder's Fee No. 99-117404.

ALSO EXCEPTING THEREFROM those portions described by instrument in favor of Clackamas County, recorded February 1, 2011 as Recorder's Fee No. 2011-007382.

ALSO EXCEPTING THEREFROM those portions described by instrument in favor of Clackamas County, recorded May 17, 2011 as Recorder's Fee No. 2011-029478.

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

In the Matter of Approving HOME Loan Subordination Agreement

Board Order No. _____

Whereas, the Clackamas County Board of County Commissioners (the "Board") has authority to sign all contracts, loans, and any amendments or renewals of the same;

Whereas, Clackamas County ("County") entered into a HOME Loan Agreement with Mt. Scott Associates Limited Partnership ("Borrower") dated as of May 27, 2004, as subsequently amended, wherein County loaned Borrower the principal amount of $450,000 ("**HOME Loan**");

Whereas Borrower has obtained refinancing to acquire limited partner interest;

Whereas, to close on the refinancing, Borrower's lender requires County to execute a subordination agreement (the "Agreement");

Whereas, due to the timing and nature of the closing of Borrower's refinance transaction, non-substantive changes may occur to the Agreement after the date of this Order, making it impossible for a final Agreement to be presented to the Board in the normal course of business;

NOW THEREFORE, the Clackamas County Board of County Commissioners resolves as follows:

1. Execution of the Agreement in substantially the form attached hereto is hereby approved;

2. The Chair of the Clackamas County Board of Commissioners or the Clackamas County Administrator are hereby delegated limited authority to sign the Agreement provided no material changes are made between the date of this Order and the closing of Borrower's refinance transaction.

[Signatures to Follow]

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

In the Matter of Approving HOME Loan Subordination Agreement

Board Order No. _____

DATED this ____ day of _____, 2021

BOARD OF COUNTY COMMISSIONERS

_____
Chair

_____
Recording Secretary

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Board of County Commissioner
Clackamas County

Members of the Board:

Approval of Amendment #3 to the Intergovernmental Agreement with the State of Oregon, acting by and through its Oregon Health Authority (OHA) for Operation as the Local Public Health Authority for Clackamas County.
Contract not to exceed $10,352,667.14 Funding is provided by the State of Oregon.
No County General Funds are involved.

Purpose/Outcomes	Amendment #3 adds $6,727,245.14
Dollar Amount and Fiscal Impact	Bringing the contract maximum value to $10,352,667.14
Funding Source	Funding through the State - No County General Funds are involved.
Duration	Effective September 1, 2021 and terminates on June 30, 2022
Previous Board Action	The Board previously reviewed and approved this agreement on July 22, 2021, Agenda item 072221-A8, October 14, 2021, Agenda item 20211014 A14
Strategic Plan Alignment	1. Funding through this Amendment allows the Clackamas County Public Health Division (CCPHD) to provide public health related services to Clackamas County residents, such as, HIV Prevention Services, Tobacco Prevention and Education, and Women's, Infants, and Children (WIC) Program 2. Ensure safe, healthy and secure communities
Counsel Review	County counsel has reviewed and approved this document on October 25, 2021 KR
Procurement Review	1. Was the item processed through Procurement? yes ☐ no ☑ 2. This item is an IGA
Contact Person	Philip Mason-Joyner, Public Health Director – (503)742-5956
Contract No.	10213-03

BACKGROUND:
The Clackamas County Public Health Division (CCPHD) of the Health, Housing & Human Services Department requests the approval of Amendment #3 adds $6,727,245.14 Bringing the contract maximum value to $10,352,667.14

Per the States directive in the Amendment, this Amendment is effective September 1, 2021 and continues through June 30, 2021 regardless of the date the Amendment is fully executed.

RECOMMENDATION:
Staff recommends the Board approval Amendment #3 to the IGA with the State of Oregon.

Respectfully submitted,
Mary Rumbaugh
Rodney A. Cook, Director
Health, Housing, and Human Services

Agreement #169503

THIRD AMENDMENT TO OREGON HEALTH AUTHORITY 2021-2023 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 Third Amendment to Oregon Health Authority 2021-2023 Intergovernmental Agreement for the Financing of Public Health Services, effective July 1, 2021, (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. OHA and LPHA are each a "Party" and together the "Parties" to the Agreement.

RECITALS

WHEREAS, OHA and LPHA wish to modify the Fiscal Year 2022 (FY22) 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. This Amendment is effective on September 1, 2021, regardless of the date this amendment has been fully executed with signatures by every Party and when required, approved by the Department of Justice. However, payments may not be disbursed until the Amendment is fully executed.

2. The Agreement is hereby amended as follows:

a. Exhibit A "Definitions", Section 18 "Program Element" is amended to add 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 01-08 COVID Wrap Direct Client Services	FF	CDC/Epidemiology and Laboratory Capacity	93.323	N	Y
PE 51-03 ARPA WF Funding	FF	CDC/Public Health Emergency Response: Cooperative Agreement for Emergency Response: Public Health Crisis Response	93.354	N	Y

b. Section 1 of Exhibit C of the Agreement, entitled "Financial Assistance Award" for FY22 is hereby superseded and replaced in its entirety by Attachment A, entitled "Financial Assistance Award (FY22)", attached hereto and incorporated herein by this reference. Attachment A must be read in conjunction with Section 3 of Exhibit C.

c. Exhibit J of the Agreement entitled "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 B, attached hereto and incorporated herein by this reference.

3. LPHA represents and warrants to OHA that the representations and warranties of LPHA set forth in Section 4 of Exhibit F of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

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

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

6. 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.

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

7. Signatures.

STATE OF OREGON, ACTING BY AND THROUGH ITS OREGON HEALTH AUTHORITY

Signature: _____

Name: /for/ Carole L. Yann

Title: Director of Fiscal and Business Operations

Date: _____

CLACKAMAS COUNTY LOCAL PUBLIC HEALTH AUTHORITY

Signature: _____

Printed Name: _____

Title: _____

Date: _____

DEPARTMENT OF JUSTICE – APPROVED FOR LEGAL SUFFICIENCY

Approved by Wendy Johnson, Senior Assistant Attorney General on July 27, 2021. Copy of emailed approval on file at OHA, OC&P.

REVIEWED BY OHA PUBLIC HEALTH ADMINISTRATION

Signature: _____

Name: Derrick Clark *(or designee)*

Title: Program Support Manager

Date: _____

Approved as to form Kathleen Rastetter 10/25/2021
for Clackamas County

Attachment A
Financial Assistance Award (FY22)

State of Oregon Oregon Health Authority Public Health Division		
1) Grantee	**2) Issue Date**	**This Action**
Name: Clackamas County	Wednesday, September 1, 2021	Amendment
Street: 2051 Kaen Rd., Suite 637		FY 2022
City: Oregon City	**3) Award Period**	
State: OR Zip: 97045-4035	From July 1, 2021 through June 30, 2022	

4) OHA Public Health Funds Approved

Number	Program	Previous Award Balance	Increase / Decrease	Current Award Balance
PE01-01	State Support for Public Health	$126,639.00	$379,697.00	$506,336.00
PE01-07	ELC ED Contact Tracing	$0.00	$0.00	$0.00
PE01-08	COVID Wrap Direct Client Services	$0.00	$19,724.87	$19,724.87
PE01-09	COVID-19 Active Monitoring - ELC	$0.00	$3,791,764.12	$3,791,764.12
PE01-10	OIP - CARES	$583,218.00	$1,244,678.15	$1,827,896.15
PE02	Cities Readiness Initiative	$42,123.00	$0.00	$42,123.00
PE07	HIV Prevention Services	$134,973.00	$0.00	$134,973.00
PE12-01	Public Health Emergency Preparedness and Response (PHEP)	$162,291.00	$0.00	$162,291.00
PE13-01	Tobacco Prevention and Education Program (TPEP)	$416,803.00	$0.00	$416,803.00
PE40-01	WIC NSA: July - September	$199,234.00	$0.00	$199,234.00
PE40-02	WIC NSA: October - June	$579,703.00	$0.00	$579,703.00
PE40-03	BFPC: July - September	$19,101.00	$0.00	$19,101.00
PE40-04	BFPC: October - June	$57,302.00	$0.00	$57,302.00
PE40-05	Farmer's Market	$8,924.00	$0.00	$8,924.00

4) OHA Public Health Funds Approved

Number	Program	Previous Award Balance	Increase / Decrease	Current Award Balance
PE42-03	MCAH Perinatal General Funds & Title XIX	$10,975.00	$0.00	$10,975.00
PE42-04	MCAH Babies First! General Funds	$35,071.00	$0.00	$35,071.00
PE42-06	MCAH General Funds & Title XIX	$20,592.00	$0.00	$20,592.00
PE42-11	MCAH Title V	$117,810.00	$0.00	$117,810.00
PE42-12	MCAH Oregon Mothers Care Title V	$9,482.00	$0.00	$9,482.00
PE43-01	Public Health Practice (PHP) - Immunization Services	$92,665.00	$0.00	$92,665.00
PE43-06	CARES Flu	$0.00	$0.00	$0.00
PE44-01	SBHC Base	$300,000.00	$0.00	$300,000.00
PE44-02	SBHC - Mental Health Expansion	$373,500.00	$0.00	$373,500.00
PE46-05	RH Community Participation & Assurance of Access	$46,174.00	$0.00	$46,174.00
PE50	Safe Drinking Water (SDW) Program (Vendors)	$176,970.00	$0.00	$176,970.00
PE51-01	LPHA Leadership, Governance and Program Implementation	$71,833.00	$909,261.00	$981,094.00
PE51-03	ARPA WF Funding	$0.00	$382,120.00	$382,120.00
PE62	Overdose Prevention-Counties	$40,039.00	$0.00	$40,039.00
		$3,625,422.00	$6,727,245.14	$10,352,667.14

5) Foot Notes:	
PE01-01	5/1/21: Bridge funding for July-Sept 2021. Additional funds to be awarded once budgets are final.
PE01-01	9/1/21: Prior comment null and void. Funding is now for FY22 7/1/2021-6/30/2022.
PE01-07	9/1/2021: Funds are available 07/01/2021 - 06/30/2023
PE01-08	9/1/2021: Funds are available 07/01/2021 - 06/30/2023
PE01-09	9/1/2021: Funds are available 7/1/2021 - 06/30/2023
PE01-10	Awarded funds can be spent on allowable costs for the period of 7/1/2021 - 6/30/2024. Any unspent funds as of 6/30/22 will be rolled over into the FY23 award. Please see provided budget guidance for more details on roll over information.
PE40-01	5/2021: All SFY2022 Q1 funding award needs to be spent down by 9/30/2021. No unspent funds carryover to Q2-4 period is allowed.
PE40-02	5/2021: SFY2022 Q2-4 funds need to be spent by 6/30/2022.
PE40-03	SFY2022 WIC BFPC grant amount is to be spent by 9/30/2021. Unspent amount is not allowed to be carried over to the following period.
PE40-04	SFY2022 WIC BFPC grant amount is to be spent by 6/30/2022. Unspent amount is not allowed to be carried over to the following period.
PE40-05	7/2021: Funds will be paid in two installments in August and October of 2021.
PE43-06	9/1/2021: Activities funded under PE43-06 are the same as PE01-10. Please use PE43-06 funds first and if possible, use by 6/30/2022. No additional funds will be added to PE43-06. Current FY22 awards are a rollover of unspent FY21 awards.
PE51-01	5/1/21: Bridge funding for July-Sept 2021. Additional funds to be awarded once budgets are final.
PE51-01	9/1/21. Prior comment null and void. Award is for FY22 7/1/2021-6/30/2022.

6) Comments:	
PE01-08	9/2021: Rollover of unspent FY21 award to FY22
PE01-09	9/2021: Rollover of unspent funds from FY21 to FY22
PE01-10	9/2021: Rollover of Unspent funds 1,244,678.15 from FY21 to FY22
PE02	7/2021: Award increase
PE13-01	07/2021: increase award from 310,126 by 106,677 to 416,803
PE40-01	5/2021: SFY22 Q1 funding: Spend $39,847 on Nutrition Ed, $6,245 on BF Promotion
PE40-02	5/2021: SFY2022 Q2-4 funding: spend $115,941 on Nutrition Ed, $18,736 on BF Promotion
PE40-03	07/2021: SFY2022 Q1 funding
PE40-04	07/2021: SFY2022 Q2-4 grant award
PE40-05	07/2021: WIC FDNP Season 2021. Funds must be spent by 12/31/2021.
PE44-02	7/2021: Funding for 21-23 Youth-Led Grants
PE51-01	9/2021: added funding for FY22
PE62	08/2021: Prior comment null and void. $12,584 available September 1- 30, 2021 only. $27,455 must be spent between July 1-August 31, 2021 only and is not eligible for carry forward; 5/2021: This award is for July 1-August 31, 2021 only.

7) Capital outlay Requested in this action:

Prior approval is required for Capital Outlay. Capital Outlay is defined as an expenditure for equipment with a purchase price in excess of $5,000 and a life expectancy greater than one year.

Program	Item Description	Cost	PROG APPROV	

Attachment B

Information required by CFR Subtitle B with guidance at 2 CFR Part 200

PE01-08 COVID Wrap Direct Client Services

Federal Award Identification Number:	NU50CD000541
Federal Award Date:	5/18/2020
Budget Performance Period:	08/01/2019-07/31/2024
Awarding Agency:	CDC
CDFA Number:	93.323
CFDFA Name:	Epidemiology and Laboratory Capacity
Total Federal Award:	98,897,708
Project Description:	Epidemiology and Laboratory Capacity
Awarding Official:	Brownie Anderson-Rana
Indirect Cost Rate:	17.64%
Research and Development (T/F):	FALSE
PCA:	53868
Index:	50401

Agency	DUNS No.	Amount	Grand Total:
Clackamas	096992656	$19,724.87	$19,724.87

PE01-09 COVID-19 Active Monitoring - ELC

Federal Award Identification Number:	NU50CK000541
Federal Award Date:	01/13/2021
Budget Performance Period:	08/01/2019-07/31/2024
Awarding Agency:	CDC
CDFA Number:	93.323
CFDFA Name:	Oregon 2020 Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC)
Total Federal Award:	348,002,156
Project Description:	Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)
Awarding Official:	Mrs. Janice Downing
Indirect Cost Rate:	17.64%
Research and Development (T/F):	FALSE
PCA:	53708
Index:	50401

Agency	DUNS No.	Amount	Grand Total:
Clackamas	096992656	$3,791,764.12	$3,791,764.12

PE01-10 OIP - CARES

Federal Award Identification Number:	NH23IP922626	
Federal Award Date:	01/15/2021	3/31/21
Budget Performance Period:	7/1/2019-6/30/2024	7/1/2019-6/30/2024
Awarding Agency:	CDC	CDC
CDFA Number:	93.268	93.268
CFDFA Name:	Immunization Cooperative Agreements	Immunization Cooperative Agreements
Total Federal Award:	38,110,851	38,627,576
Project Description:	Immunization and Vaccines for Children	Immunization and Vaccines for Children
Awarding Official:	Divya Cassity	Divya Cassity
Indirect Cost Rate:	17.64	17.64
Research and Development (T/F):	FALSE	FALSE
PCA:	53120	53895
Index:	50404	50404

Agency	DUNS No.	Amount	Amount	Grand Total:
Clackamas	096992656	$1,244,678.15	$583,218.00	$1,827,896.15

PE51-03 ARPA WF Funding

Federal Award Identification Number:	NU90TP922194
Federal Award Date:	5/19/2021
Budget Performance Period:	07/01/2021-06/30/2023
Awarding Agency:	CDC
CDFA Number:	93.354
CFDFA Name:	Public Health Emergency Response: Cooperative Agreement for Emergency Response: Public Health Crisis Response
Total Federal Award:	25,667,917
Project Description:	Public Health Emergency Response: Cooperative Agreement for Emergency Response: Public Health Crisis Response
Awarding Official:	Sylvia Reeves
Indirect Cost Rate:	17.64%
Research and Development (T/F):	FALSE
PCA:	50272
Index:	50107

Agency	DUNS No.	Amount	Grand Total:
Clackamas	096992656	$382,120.00	$382,120.00

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval to accept funding from Oregon Health Authority (OHA) for Elimination of Behavioral Health Inequities. Funding agreement is for $50,000.
No County General Funds are involved.

Purpose/Outcomes	Identify the current behavioral health inequities in services for people with behavioral health needs and make recommendations for how best invest the funds from the appropriation. Develop a plan to invest available funds and increase culturally and linguistically appropriate residential treatment and housing capacity.
Dollar Amount and Fiscal Impact	The maximum agreement value is $50,000. No County General Funds are involved. No matching funds required.
Funding Source	Oregon Health Authority (OHA)
Duration	Effective upon execution of the Grant Agreement and terminates on June 30, 2022
Previous Board Action	October 14, 2021 A.4: Approval to Apply
Strategic Plan Alignment	1. Improve community safety and health 2. Ensure safe, healthy and secure communities by investing funds to expand Behavioral Health services to the citizens of Clackamas County
Counsel Review	1. 10/27/21 2. KR
Procurement Review	1. Was the item process through Procurement? Yes ☐ No ☒ 2. This is a direct procurement of a grant award.
Contact Person	Deborah Cockrell, Health Centers Division Director – 503-742-5495
Contract No.	10357

BACKGROUND:

Clackamas County Health Centers Division (CCHCD) of the Health, Housing & Human Services Department requests the approval to accept award 172812 from the Oregon Health Authority (OHA). Health Centers-Behavioral Health has partnered with Oregon Health Equity Alliance to complete an organizational racial assessment, the Barhii. This assessment will help guide areas of strength and need within the organization. Funds will offset the cost of time for steering committee members who will meet and organize this work and also those who are facilitating focus groups.

The award has a maximum value of $50,000. It is effective upon execution of the grant agreement and terminates June 30, 2022.

RECOMMENDATION:
Staff recommends the Board approval.

Respectfully submitted,

Mary Rumbaugh

Rodney A. Cook, Director
Health, Housing and Human Services

#10357

Grant Agreement Number 172812

STATE OF OREGON
INTERGOVERNMENTAL GRANT AGREEMENT

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

This Agreement is between the State of Oregon, acting by and through its Oregon Health Authority, hereinafter referred to as "OHA," and

Clackamas County
Acting by and through its Clackamas Health Centers
2051 Kaen Road, Suite 367
Oregon City, Oregon 97045
Attention: Emily Ketola
Telephone: (503) 722-6258
E-mail address: eketola@clackamas.us

hereinafter referred to as "Recipient."

The Program to be supported under this Agreement relates principally to OHA's

Health Systems Division
500 Summer Street NE E86
Salem, Oregon 97301-1118
Agreement Administrator: George Carrillo or delegate
Telephone: (503) 930-5230
E-mail address: george.carrillo@dhsoha.state.or.us

1. Effective Date and Duration.

This Agreement shall become effective on the date this Agreement has been fully executed by every party and, when required, approved by Department of Justice. Unless extended or terminated earlier in accordance with its terms, this Agreement shall expire on **June 30, 2022**, exclusive of reporting requirements which are due no later than August 15, 2022. Agreement termination shall not extinguish or prejudice OHA's right to enforce this Agreement with respect to any default by Recipient that has not been cured.

2. Agreement Documents.

a. This Agreement consists of this document and includes the following listed exhibits which are incorporated into this Agreement:

(1) Exhibit A, Part 1: Program Description

(2) Exhibit A, Part 2: Payment and Financial Reporting

(3) Exhibit B: Standard Terms and Conditions

(4) Exhibit C: Subcontractor Insurance Requirements

(5) Exhibit D: Recipient's Proposal

There are no other Agreement documents unless specifically referenced and incorporated in this Agreement.

b. In the event of a conflict between two or more of the documents comprising this Agreement, the language in the document with the highest precedence shall control. The documents comprising this Agreement shall be in the following descending order of precedence: this Agreement less all exhibits, Exhibits B, A, D and C.

3. Grant Disbursement Generally.

The maximum not-to-exceed amount payable to Recipient under this Agreement, which includes any allowable expenses, is **$50,000.00**. OHA will not disburse grant to Recipient in excess of the not-to-exceed amount and will not disburse grant until this Agreement has been signed by all parties. OHA will disburse the grant to Recipient as described in Exhibit A.

4. Contractor or Subrecipient Determination.

In accordance with the State Controller's Oregon Accounting Manual, policy 30.40.00.104, OHA's determination is that:

☐ Recipient is a subrecipient ☐ Recipient is a contractor ☒ Not applicable

Catalog of Federal Domestic Assistance (CFDA) #(s) of federal funds to be paid through this Agreement: N/A

5. Recipient Data and Certification.

a. Recipient Information. Recipient shall provide the information set forth below.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Recipient Name (exactly as filed with the IRS): COUNTY OF CLACKAMAS, OREGON

Street address:	2051 KAEN RD
City, state, zip code:	OREGON CITY, OR 97045
Email address:	DCOCKRELL@CLACKAMAS.US
Telephone:	(503) 742-5495 Facsimile: (503) 742-5979

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

Workers' Compensation Insurance Company: SELF-INSURED

Policy #: _____ Expiration Date: _____

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

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

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

the Recipient;

(3) The information shown in this Section 5a. "Recipient Information", is Recipient's true, accurate and correct information;

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

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

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

(7) Recipient is not subject to backup withholding because:

(a) Recipient is exempt from backup withholding;

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

(c) The IRS has notified Recipient that Recipient is no longer subject to backup withholding; and

(8) Recipient Federal Employer Identification Number (FEIN) or Social Security Number (SSN) provided is true and accurate. If this information changes, Recipient is required to provide OHA with the new FEIN within 10 days.

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

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

Clackamas County
Acting by and through its Clackamas Health Centers
By:

Authorized Signature	Printed Name
Title	Date

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

Authorized Signature	Printed Name
Title	Date

Approved by OHA, Health Systems Division
By:

Authorized Signature	Printed Name
Title	Date

Approved for Legal Sufficiency:

Not required per OAR 137-045-0030(1)(a).

EXHIBIT A

Program Description

1. Background.

In partnership with communities, OHA is transforming Oregon's behavioral health system. Recipient will partner with OHA to work towards the goals of eliminating health inequities by 2030. Governor Brown and the Oregon Legislature have taken action to support this work. The 2021 Oregon Legislature in HB 5024 (Regular Session 2021) appropriated $130 million to support regional community investments that will ensure people with behavioral health service needs have culturally and linguistically appropriate housing and residential service options.

2. Purpose.

These funds awarded under this Grant Agreement will support partnerships among community-based organizations, counties, Coordinated Care Organizations (CCOs), and other entities to identify the current gaps in housing and facility-based residential services for people with behavioral health needs and make recommendations for how to best invest the funds from the appropriation. OHA will work in consultation with the grantees, other community members, Oregon Housing and Community Services, and OHA's advisory councils to develop a plan to invest available funds and increase culturally and linguistically appropriate residential treatment and housing capacity.

3. Allowable Activities.

Recipient will provide the following Grant Activities under this Agreement:

a. Grant funds will be used on promoting collaboration and planning to increase behavioral health residential treatment and housing capacity among individuals and groups experiencing inequities in access to health care resources. Recipient will follow Recipient's Proposal, as identified in Exhibit D.

b. Provide access to interpretation services. Recipient shall work with the OHA Agreement Administrator if Recipient does not have staff that fluently speak the language of an eligible individual, including qualified sign language interpreters for individuals who are deaf or hard of hearing and whose preferred mode of communication is sign language.

c. Provide documents in alternate languages and formats, including accessible electronic formats, braille documents, and large print upon request. If Recipient does not have access to such languages or formats, then Recipient can request them from OHA by contacting the OHA Agreement Administrator.

d. Participate in meetings with OHA, as requested, to share lessons learned and recommendations.

4. Reporting Requirements.

Recipient shall electronically submit the following report to the OHA Agreement Administrator listed on page 1 of this Agreement, with a CC to AMHcontract.Administrator@dhsoha.state.or.us:

a. Progress Report. Recipient shall provide two progress reports, which include at a minimum a summary of efforts and outcomes, outcome data, and/or project updates in relation to ensuring people with behavioral health service needs have culturally and linguistically appropriate housing and residential service options within the state of Oregon.

i. The first progress report is due no later than December 31, 2021.

ii. The second progress report should build on the first progress report and is due no later than April 30, 2022.

b. Recommendation Report. Recipient shall provide a final Recommendation Report, which includes at a minimum, a summary of all efforts and outcomes, outcome data, and/or project updates in relation to ensuring people with behavioral health service needs have culturally and linguistically appropriate housing and residential service options within the state of Oregon, which is due no later than August 15, 2022.

c. Expenditure Attestation. Recipient shall provide the attestation referenced in Exhibit A, Part 2, Section 1.c. of this Grant Agreement no later than August 15, 2022.

EXHIBIT A

Part 2

Payment and Financial Reporting

1. Payment and Financial Reporting.

a. OHA no longer issues paper checks. To receive grant funding, Recipient must enroll in Electronic Funds Transfer (EFT), also known as direct deposit. To enroll, Recipient must submit a completed Direct Deposit Authorization Form found at: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/me0189.docx. If Recipient already has EFT set up for any type of payment that comes from the Oregon Department of Human Services (ODHS) or OHA, Recipient should not send in another form. Recipient may contact the EFT Coordinator at (503) 945-5710 for technical assistance. Due to the confidential nature of bank account information, Recipient should only provide bank information to the EFT Coordinator or OHA Financial Services.

b. OHA will grant funds on the following schedule:

i. Upon execution of this Grant Agreement, OHA will initiate the direct deposit of **$50,000.00** to Recipient for the Grant Activities listed in Exhibit A, Part 1.

c. Recipient shall ensure that all funding provided under this Agreement is spent by June 30, 2022. An attestation of such funds must be sent to the OHA email box at amhcontract.administrator@dhsoha.state.or.us by August 15, 2022, or to any other address as OHA may indicate in writing to Recipient, in a format prescribed by OHA.

2. Travel and Other Expenses.

OHA will not reimburse Recipient separately for any travel or other expenses under this Agreement.

EXHIBIT B
Standard Terms and Conditions

1. Governing Law, Consent to Jurisdiction.

This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively, "Claim") between OHA or any other agency or department of the State of Oregon, or both, and Recipient that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a Claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this Section be construed as a waiver by the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any Claim, whether sovereign immunity, governmental immunity, immunity based on the eleventh amendment to the Constitution of the United States or otherwise. Each party hereby consents to the exclusive jurisdiction of such court, waives any objection to venue, and waives any claim that such forum is an inconvenient forum. This Section shall survive expiration or termination of this Agreement.

2. Compliance with Law.

Recipient shall comply with all federal, state and local laws, regulations, executive orders and ordinances applicable to the Recipient and this Agreement. This Section shall survive expiration or termination of this Agreement.

3. Independent Parties.

The parties agree and acknowledge that their relationship is that of independent parties and that Recipient is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

4. Grant Funds; Payments.

a. Recipient is not entitled to compensation under this Agreement by any other agency or department of the State of Oregon. Recipient understands and agrees that OHA's participation in this Agreement is contingent on OHA receiving appropriations, limitations, allotments or other expenditure authority sufficient to allow OHA, in the exercise of its reasonable administrative discretion, to participate in this Agreement.

b. Disbursement Method. Disbursements under this Agreement will be made by Electronic Funds Transfer (EFT) and shall be processed in accordance with the provisions of OAR 407-120-0100 through 407-120-0380 or OAR 410-120-1260 through OAR 410-120-1460, as applicable, and any other OHA Oregon Administrative Rules that are program-specific to the billings and payments. Upon request, Recipient must provide its taxpayer identification number (TIN)

and other necessary banking information to receive EFT payment. Recipient must maintain at its own expense a single financial institution or authorized payment agent capable of receiving and processing EFT using the Automated Clearing House (ACH) transfer method. The most current designation and EFT information will be used for all disbursements under this Agreement. Recipient must provide this designation and information on a form provided by OHA. In the event that EFT information changes or the Recipient elects to designate a different financial institution for the receipt of any payment made using EFT procedures, Recipient will provide the changed information or designation to OHA on a OHA-approved form.

5. Recovery of Overpayments.

Any funds disbursed to Recipient under this Agreement that are expended in violation or contravention of one or more of the provisions of this Agreement ("Misexpended Funds") or that remain unexpended ("Unexpended Funds") on the earlier of termination or expiration of this Agreement must be returned to OHA. Recipient shall return all Misexpended Funds to OHA promptly after OHA's written demand and no later than 15 days after OHA's written demand. Recipient shall return all Unexpended Funds to OHA within 14 days after the earlier of termination or expiration of this Agreement**.** OHA, in its sole discretion, may recover Misexpended or Unexpended Funds by withholding from payments due to Recipient such amounts, over such periods of time, as are necessary to recover the amount of the overpayment. Prior to withholding, if Recipient objects to the withholding or the amount proposed to be withheld, Recipient shall notify OHA that it wishes to engage in dispute resolution in accordance with Section 14 of this Exhibit.

6. Ownership of Work Product. Reserved.

7. Contribution.

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

With respect to a Third Party Claim for which the State is jointly liable with the Recipient (or would be if joined in the Third Party Claim), the State shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by the Recipient in such proportion as is appropriate to reflect the relative fault of the State on the one hand and of the Recipient on the other hand in connection with the events which resulted in such

expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of the State on the one hand and of the Recipient on the other hand shall be determined by reference to, among other things, the parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. The State's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if the State had sole liability in the proceeding.

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

This Section shall survive expiration or termination of this Agreement.

8. Indemnification by Subcontractors.

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

9. Default; Remedies; Termination.

a. Default by Recipient. Recipient shall be in default under this Agreement if:

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

(2) Any representation, warranty or statement made by Recipient herein or in any documents or reports relied upon by OHA to measure compliance with this Agreement, the expenditure of disbursements or the desired outcomes by Recipient is untrue in any material respect when made;

(3) Recipient (1) applies for or consents to the appointment of, or taking of possession by, a receiver, custodian, trustee, or liquidator of itself or all of its property, (2) admits in writing its inability, or is generally unable, to pay its debts as they become due, (3) makes a general assignment for the benefit of its creditors, (4) is adjudicated a bankrupt or insolvent, (5) commences a voluntary case under the Federal Bankruptcy Code (as now or hereafter in effect), (6) files a petition seeking to take advantage of any other law relating to bankruptcy, insolvency, reorganization, winding-up, or composition or adjustment of debts, (7) fails to controvert in a timely and appropriate manner, or acquiesces in writing to, any petition filed against it in an involuntary case under the Bankruptcy Code, or (8) takes any action for the purpose of effecting any of the foregoing; or

(4) A proceeding or case is commenced, without the application or consent of Recipient, in any court of competent jurisdiction, seeking (1) the liquidation, dissolution or winding-up, or the composition or readjustment of debts, of Recipient, (2) the appointment of a trustee, receiver, custodian, liquidator, or the like of Recipient or of all or any substantial part of its assets, or (3) similar relief in respect to Recipient under any law relating to bankruptcy, insolvency, reorganization, winding-up, or composition or adjustment of debts, and such proceeding or case continues undismissed, or an order, judgment, or decree approving or ordering any of the foregoing is entered and continues unstayed and in effect for a period of sixty consecutive days, or an order for relief against Recipient is entered in an involuntary case under the Federal Bankruptcy Code (as now or hereafter in effect).

b. OHA's Remedies for Recipient's Default. In the event Recipient is in default under Section 9.a., OHA may, at its option, pursue any or all of the remedies available to it under this Agreement and at law or in equity, including, but not limited to:

(1) termination of this Agreement under Section 9.c.(2);

(2) withholding all or part of monies not yet disbursed by OHA to Recipient;

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

(4) exercise of its right of recovery of overpayments under Section 5. of this Exhibit B.

These remedies are cumulative to the extent the remedies are not inconsistent, and OHA may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever. If a court determines that Recipient was not in default under Section 9.a., then Recipient shall be entitled to the same remedies as if this Agreement was terminated pursuant to Section 9.c.(1).

c. Termination.

(1) OHA's Right to Terminate at its Discretion. At its sole discretion, OHA may terminate this Agreement:

(a) For its convenience upon 30 days' prior written notice by OHA to Recipient;

(b) Immediately upon written notice if OHA fails to receive funding, appropriations, limitations, allotments or other expenditure authority at levels sufficient to continue supporting the program; or

(c) Immediately upon written notice if federal or state laws, regulations, or guidelines are modified or interpreted in such a way that OHA's support of the program under this Agreement is prohibited or OHA is prohibited from paying for such support from the planned funding source.

(d) Immediately upon written notice to Recipient if there is a threat to the health, safety, or welfare of any person receiving funds or benefitting from services under this Agreement "OHA Client", including any Medicaid Eligible Individual, under its care.

(2) OHA's Right to Terminate for Cause. In addition to any other rights and remedies OHA may have under this Agreement, OHA may terminate this Agreement immediately upon written notice to Recipient, or at such later date as OHA may establish in such notice if Recipient is in default under Section 9.a.

(3) Mutual Termination. The Agreement may be terminated immediately upon mutual written consent of the parties or at such other time as the parties may agree in the written consent.

(4) Return of Property. Upon termination of this Agreement for any reason whatsoever, Recipient shall immediately deliver to OHA all of OHA's property that is in the possession or under the control of Recipient at that time. This Section 9.c.(4) survives the expiration or termination of this Agreement.

(5) Effect of Termination. Upon receiving a notice of termination of this Agreement or upon issuing a notice of termination to OHA, Recipient shall immediately cease all activities under this Agreement unless, in a notice issued by OHA, OHA expressly directs otherwise.

10. Insurance.

All employers, including Recipient, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). Recipient shall require subcontractors to maintain insurance as set forth in Exhibit C, which is attached hereto.

11. Records Maintenance, Access.

Recipient shall maintain all financial records relating to this Agreement in accordance with generally accepted accounting principles. In addition, Recipient shall maintain any other records, books, documents, papers, plans, records of shipments and payments and

writings of Recipient, whether in paper, electronic or other form, that are pertinent to this Agreement, in such a manner as to clearly document Recipient's performance. All financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Recipient whether in paper, electronic or other form, that are pertinent to this Agreement, are collectively referred to as "Records." Recipient acknowledges and agrees that OHA and the Secretary of State's Office and the federal government and their duly authorized representatives shall have access to all Records to perform examinations and audits and make excerpts and transcripts. Recipient shall retain and keep accessible all Records for the longest of:

a. Six years following final payment and termination of this Agreement;

b. The period as may be required by applicable law, including the records retention schedules set forth in OAR Chapter 166; or

c. Until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement.

12. Information Privacy/Security/Access.

If this Agreement requires or allows Recipient or, when allowed, its subcontractor(s), to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Recipient or its subcontractor(s) access to such OHA Information Assets or Network and Information Systems, Recipient shall comply and require all subcontractor(s) to which such access has been granted to comply with OAR 943-014-0300 through OAR 943-014-0320, as such rules may be revised from time to time. For purposes of this Section, "Information Asset" and "Network and Information System" have the meaning set forth in OAR 943-014-0305, as such rule may be revised from time to time.

13. Assignment of Agreement, Successors in Interest.

a. Recipient shall not assign or transfer its interest in this Agreement without prior written consent of OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions required by OHA. No approval by OHA of any assignment or transfer of interest shall be deemed to create any obligation of OHA in addition to those set forth in this Agreement.

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

14. Resolution of Disputes.

The parties shall attempt in good faith to resolve any dispute arising out of this Agreement. In addition, the parties may agree to utilize a jointly selected mediator or arbitrator (for non-binding arbitration) to resolve the dispute short of litigation. This Section shall survive expiration or termination of this Agreement.

15. Subcontracts.

Recipient shall not enter into any subcontracts for any part of the program supported by this Agreement without OHA's prior written consent. In addition to any other provisions OHA may require, Recipient shall include in any permitted subcontract under this Agreement provisions to ensure that OHA will receive the benefit of subcontractor activity(ies) as if the subcontractor were the Recipient with respect to Sections 1, 2, 3, 6, 7, 8, 10, 11, 12, 13, 15, 16, and 17 of this Exhibit B. OHA's consent to any subcontract shall not relieve Recipient of any of its duties or obligations under this Agreement.

16. No Third Party Beneficiaries.

OHA and Recipient 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 any greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement. This Section shall survive expiration or termination of this Agreement.

17. Severability.

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

18. Notice.

Except as otherwise expressly provided in this Agreement, any communications between the parties hereto or notices to be given hereunder shall be given in writing by personal delivery, facsimile, e-mail, or mailing the same, postage prepaid to Recipient or OHA at the address or number set forth in this Agreement, or to such other addresses or numbers as either party may indicate pursuant to this Section. Any communication or notice so addressed and mailed by regular mail shall be deemed received and effective five days after the date of mailing. Any communication or notice delivered by e-mail shall be deemed received and effective five days after the date of e-mailing. Any communication or notice delivered by facsimile shall be deemed received and effective on the day the transmitting machine generates a receipt of the successful transmission, if transmission was during normal business hours of the Recipient, or on the next business day if transmission was outside normal business hours of the Recipient. Notwithstanding the foregoing, to be effective against the other party, any notice transmitted by facsimile must be confirmed by telephone notice to the other party. Any communication or notice given by personal delivery shall be deemed effective when actually delivered to the addressee.

OHA: Office of Contracts & Procurement

635 Capitol Street NE, Suite 350
Salem, OR 97301
Telephone: 503-945-5818
Fax: 503-378-4324

This Section shall survive expiration or termination of this Agreement.

19. Headings.

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

20. Amendments; Waiver; Consent.

OHA may amend this Agreement to the extent provided herein, the solicitation document, if any from which this Agreement arose, and to the extent permitted by applicable statutes and administrative rules. No amendment, waiver, or other consent under this Agreement shall bind either party unless it is in writing and signed by both parties and when required, the Department of Justice. Such amendment, waiver, or consent 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 that party of that or any other provision. This Section shall survive the expiration or termination of this Agreement.

21. Merger Clause.

This Agreement constitutes the entire agreement between the parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein, regarding this Agreement.

22. Limitation of Liabilities.

NEITHER PARTY SHALL BE LIABLE TO THE OTHER FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT. NEITHER PARTY SHALL BE LIABLE FOR ANY DAMAGES OF ANY SORT ARISING SOLELY FROM THE TERMINATION OF THIS AGREEMENT OR ANY PART HEREOF IN ACCORDANCE WITH ITS TERMS.

EXHIBIT C

SUBCONTRACTOR INSURANCE

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

1. WORKERS' COMPENSATION & EMPLOYERS' LIABILITY

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

2. COMMERCIAL GENERAL LIABILITY:

☒ **Required**

Commercial General Liability Insurance covering bodily injury and property damage in a form and with coverage that are satisfactory to the State. This insurance shall include personal and advertising injury liability, products and completed operations, contractual liability coverage for the indemnity provided under this contract, and have no limitation of coverage to designated premises, project or operation. Coverage shall be written on an occurrence basis in an amount of

not less than $1,000,000.00 per occurrence. Annual aggregate limit shall not be less than $2,000,000.00.

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

Professional Liability insurance covering any damages caused by an error, omission or any negligent acts related to the services to be provided under this Contract by the Contractor and Contractor's subcontractors, agents, officers or employees in an amount not less than $1,000,000.00 per claim. Annual aggregate limit shall not be less than $2,000,000.00. If coverage is on a claims made basis, then either an extended reporting period of not less than 24 months shall be included in the Professional Liability insurance coverage, or the Contractor shall provide Tail Coverage as stated below.

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

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

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

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

8. TAIL COVERAGE:
If any of the required insurance is on a claims made basis and does not include an extended reporting period of at least 24 months, Contractor shall maintain either tail coverage or continuous claims made liability coverage, provided the effective date of the continuous claims made coverage is on or before the effective date of this Subcontract, for a minimum of 24

months following the later of (i) Contractor's completion and Recipient's acceptance of all Services required under this Subcontract, or, (ii) Recipient's or Contractor termination of contract, or, iii) The expiration of all warranty periods provided under this Subcontract.

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

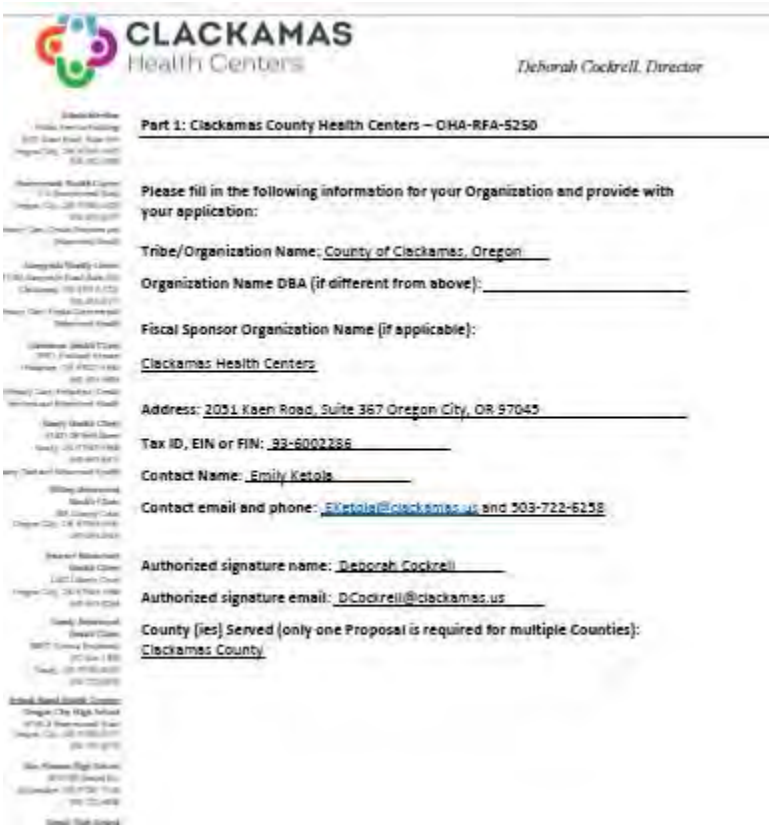
10. NOTICE OF CHANGE OR CANCELLATION:
The Contractor or its insurer must provide at least 30 days' written notice to Recipient before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

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

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

Exhibit D

Recipient's Proposal



CLACKAMAS Health Centers

Deborah Cockrell, Director

Part 1: Clackamas County Health Centers – OHA-RFA-5250

Please fill in the following information for your Organization and provide with your application:

Tribe/Organization Name: County of Clackamas, Oregon

Organization Name DBA (if different from above):

Fiscal Sponsor Organization Name (if applicable):

Clackamas Health Centers

Address: 2051 Kaen Road, Suite 367 Oregon City, OR 97045

Tax ID, EIN or FIN: 93-6002286

Contact Name: Emily Ketola

Contact email and phone: EKetola@clackamas.us and 503-722-6258

Authorized signature name: Deborah Cockrell

Authorized signature email: DCockrell@clackamas.us

County (ies) Served (only one Proposal is required for multiple Counties):
Clackamas County

CLACKAMAS
Health Centers

Deborah Cockrell, Director

September 1, 2021

Coral Ford
Procurement and Contract Specialist 3
OHA Office of Contracts and Procurement
635 Capitol Street NE, Suite 350
Salem, OR 97301

RE: Letter of intent to access grant funding offered via Request for Grant Proposals
OHA-RFA-5250, OregonBuys S-44300-00000496

Part 2: Clackamas County Health Centers – OHA-RFA-5250

Clackamas Health Centers is seeking grant funding to support the elimination of behavioral health inequities. Clackamas Health Centers – Behavioral Health has collaborated with Oregon Health Equity Alliance (OHEA) to complete an organizational racial equity assessment, the Barhii. This assessment will help guide areas of strength and need within our organization as determined by many voices, including those who are consumers of our services. The data will be analyzed and ultimately will produce action items to focus on to address health equity.

The Barhii assessment includes providing a survey to all of our Behavioral Health staff as well as management. We will be surveying community partners, 10-20 different agencies, including but not limited to: Clackamas Women's Services (Domestic violence), Health Centers Primary care and Dental Services, Folktime (peer support), Community corrections, CSAP, County jail, DHS, Zero Suicide initiative, Older Adult initiative and program liaison, Vocation Rehabilitation, and Clackamas County Equity and Inclusion Office. We have built numerous collaborations with community partners over the years to provide the most supportive services to our community members and these partners will have a keen perspective on the work we do to address racial inequities.

We will also survey clients (100-200 clients) with lived experience of managing behavioral health symptoms. Clients who respond will be receiving a range of

services including mental health services, substance use treatment, co-occurring treatment, medication management, Supported Employment, peer services, and individual/ family/ group therapy. Clients will be part of an array of our programs including Child and Family, Community Support team which services individuals wish SPMI, Adult Mental Health, Adult and Adolescent Substance Use and Specialty Court programs. We will also be facilitating focus groups (approximately 1-2 hours in length) for all Behavioral Health staff to gather more narrative accounts of their experiences in their work and with clients.

There has been a strong push for action around equity and inclusion within Behavioral Health work and this assessment provides a strong framework to guide discussion and next steps that uses immediate data and voice of those we serve and those we work with. This assessment requires significant time for preparation and completion. Our contract with Oregon Health Equity Alliance has been for support with aligning our assessment with a previously completed racial justice charter and consulting on roll out of the assessment. However the actual assessment work is being completed by staff, who already hold other jobs and are integrating this necessary work in to their current positions. I would like to request that we use this grant funding to offset the cost of time for steering committee members who have been meeting and organizing this work and also those who are facilitating focus groups. The steering committee is made up of 3 members who have regular meetings and also who complete work outside of meetings. I would also like to request funding to provide food to clients who complete the surveys. This could be in the form of actual food on site or gift cards if they are completing these virtually. Client voice is imperative to our data and we want to show our value in clients taking the time to share honest feedback about their experiences in our services. The remaining funds would be utilized to contract with Oregon Health Equity Alliance or other EDI focused contractors to assist with analysis of Barhii results, action steps planning to operationalize the recommendations and additional training opportunities for staff in this important work.

Our community deserves for our behavioral health services to place action to voice. We have an anti-racist belief and approach to the work and are prepared to make practical changes so this is experienced at all levels of our services and work.

Proposed Budget:

Personnel	Hourly Cost	Total Hours	Total Cost
Montiel,Damaris O	$ 54.05	87	$ 4,702.08
Kmiola,Emily	$ 98.66	45	$ 4,439.58
Joslin,Amy	$ 72.47	45	$ 3,261.06
Total Personnel			**$ 12,402.73**
Supplies/Incentives			
Gift Cards	$ 15.00	200	$ 3,000.00
Training			$ 14,600.00
Contract-OHEA			$ 20,000.00
Total Supplies/Incentives			**$ 37,600.00**
Total Cost			**$ 50,002.73**

Confidential

CONTRACTOR TAX IDENTIFICATION INFORMATION

For Accounting Purposes Only

The State of Oregon requires contractors to provide their Federal Employer Identification Number (FEIN) or Social Security Number (SSN). This information is requested pursuant to ORS 305.385 and OAR 125-246-0330(2). Social Security numbers provided pursuant to this section will be used for the administration of state, federal and local tax laws. The State of Oregon may report this information to the Internal Revenue Service (IRS). Contractors must keep this information current at all times. Contractors are required to notify the State of Oregon contract administrator within 10 business days if this information changes. The State of Oregon reserves the right to ask contractors to update this information at any time during the document term.

Document number: _____

Legal name *(tax filing)*: _____

DBA name *(if applicable)*: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Phone: _____

FEIN: _____

- OR -

SSN: _____

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of an Intergovernmental Agreement with the Gladstone School District to embed a Mental Health Specialist at Gladstone High School. Contract not to exceed $61,521 for one year. This is a revenue agreement.
No County General Funds are involved.

Purpose/Outcomes	The purpose of this agreement is to embed a Mental Health Specialist at Gladstone School District to provide mental health and behavioral health services.
Dollar Amount and Fiscal Impact	This is a revenue agreement for $61,521.00
Funding Source	No County funds. This is a revenue agreement with Gladstone School District.
Duration	Upon signature – June 30, 2022
Previous Board Action	No previous board action.
Strategic Plan Alignment	1. Individuals and families in need are healthy and safe. 2. Ensure safe, healthy and secure communities by providing mental and behavioral health services to students at Gladstone High School.
Counsel Review	1. November 8, 2021 2. KR
Procurement Review	1. Was the item process through Procurement? Yes ☐ No ☒ 2. Original contract amount was direct procurement.
Contact Person	Deborah Cockrell, Health Center Director – 503-742-5495
Contract No.	10399

BACKGROUND:
Clackamas County Health Centers Division (CCHCD) of the Health, Housing & Human Services Department requests the approval of Intergovernmental agreement #10399 with Gladstone School District. CCHCD will provide behavioral health staff to be located at Gladstone High School approximately 2.5 days a week during the school year. The work the behavioral health staff will be doing is three-fold. They will be providing consultation and education for school counselors and staff, screening and coordination of care for students, and providing direct behavioral health therapy.

CCHCD will receive $61,521.00 from Gladstone School District under this agreement. This agreement is effective upon signature and will terminate June 30, 2022.

RECOMMENDATION:
Staff recommends approval of agreement.

Respectfully submitted,

Mary Rumbaugh

Rodney A. Cook, Director
Health, Housing & Human Services Department

#10399

INTERGOVERNMENTAL AGREEMENT BETWEEN CLACKAMAS COUNTY AND GLADSTONE SCHOOL DISTRICT

THIS AGREEMENT (this "Agreement") is entered into and between Clackamas County, acting by and through it Health Centers Division (CHCD) ("County"), a political subdivision of the State of Oregon, and Gladstone School District (GSD) ("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.

The County desires to contract with the Agency to embed a Mental Health Specialist 2 at Gladstone High School to provide mental health and behavioral health services.

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, 2022, whichever is sooner.
2. **Scope of Work.** The County agrees to provide the services further identified in the Scope of Work attached hereto as Exhibit A and incorporated herein ("Work").
3. **Consideration.** The Agency agrees to pay County, from available and authorized funds, a sum not to exceed sixty one thousand five hundred twenty one dollars ($61,521.00) for accomplishing the Work required by this Agreement.
4. **Payment.** Agency shall pay County $61,521.00 upon receipt of the signed agreement. Payment shall be submitted to:

   Clackamas Health Centers Division
   2051 Kaen Road, #367
   Oregon City, OR 97045

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. Any termination of this Agreement shall not prejudice any rights or obligations accrued to the Parties prior to termination.

7. **Indemnification**.

A. Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the County agrees to indemnify, save harmless and defend the Agency, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the County or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the County has a right to control.

B. Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the Agency agrees to indemnify, save harmless and defend the County, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the Agency or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the Agency has a right to control.

8. **Insurance.** The Agency agrees to furnish the County with evidence of commercial general liability insurance with a combined single limit of not less than $1,000,000 for

each claim, incident, or occurrence, with an aggregate limit of $2,000,000 for bodily injury and property damage for the protection of Clackamas County, and their officers, elected officials, agents, and employees against liability for damages because of personal injury, bodily injury, death or damage to property, including loss of use thereof, in any way related to this Agreement. If self-insured, Agency shall provide documentation to the County of Agency's self-insured status by completing the Self-Insurance Certification form provided by the County.

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. Ben DeGiulio or their designee will act as liaison for the County.

      Contact Information:

      bdgiulio@clackamas.us

      Bob Stewart or their designee will act as liaison for the Agency.

      Contact Information:

      bob@gladstone.k12.or.us

10. **General Provisions.**

   A. **Oregon Law and Forum.** This Agreement, and all rights, obligations, and disputes arising out of it will be governed by and construed in accordance with the laws of the State of Oregon and the ordinances of Clackamas County without giving effect to the conflict of law provisions thereof. Any claim between County and Agency that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Clackamas County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the County of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. Agency, by execution of this Agreement, hereby consents to the in personam jurisdiction of the courts referenced in this section.

   B. **Compliance with Applicable Law**. Both Parties shall comply with all applicable local, state and federal ordinances, statutes, laws and regulations. All provisions of

law required to be a part of this Agreement, whether listed or otherwise, are hereby integrated and adopted herein. Failure to comply with such obligations is a material breach of this Agreement.

C. **Non-Exclusive Rights and Remedies**. Except as otherwise expressly provided herein, the rights and remedies expressly afforded under the provisions of this Agreement shall not be deemed exclusive, and shall be in addition to and cumulative with any and all rights and remedies otherwise available at law or in equity. The exercise by either Party of any one or more of such remedies shall not preclude the exercise by it, at the same or different times, of any other remedies for the same default or breach, or for any other default or breach, by the other Party.

D. **Access to Records**. Agency shall retain, maintain, and keep accessible all records relevant to this Agreement ("Records") for a minimum of six (6) years, following Agreement termination or full performance or any longer period as may be required by applicable law, or until the conclusion of an audit, controversy or litigation arising out of or related to this Agreement, whichever is later. Agency shall maintain all financial records in accordance with generally accepted accounting principles. All other Records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, Agency shall permit the County's authorized representatives' access to the Records at reasonable times and places for purposes of examining and copying.

E. **Work Product.** All work performed under this Agreement shall be considered work made for hire and shall be the sole and exclusive property of the County. The County shall own any and all data, documents, plans, copyrights, specifications, working papers and any other materials produced in connection with this Agreement. On completion or termination of the Agreement, the Agency shall promptly deliver these materials to the County's Project Manager.

F. **Hazard Communication.** Agency shall notify County prior to using products containing hazardous chemicals to which County employees may be exposed, which includes any hazardous, toxic, or dangerous substance, waste, or material that is the subject of environmental protection legal requirements or that becomes regulated under any applicable local, state or federal law, including but not limited to the items listed in the United States Department of Transportation Hazardous Materials Table (49 CFR §172.101) or designated as hazardous substances by Oregon Administrative Rules, Chapter 137, or the United States Environmental Protection Agency (40 CFR Part 302), and any amendments thereto. Upon County's request, Agency shall immediately provide Material Safety Data Sheets for the products subject to this provision.

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 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.

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 County, which shall be granted or denied in the County's sole discretion. County's consent to any subcontract shall not relieve Agency of any of its duties or obligations under this Agreement.

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 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.

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 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.

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.

Clackamas County

_____
Chair, Board of County Commissioners

_____
Date

Gladstone School District

Rachel Lopez Hopper, CFO

11/8/2021

Approved as to form: Kathleen J. Rastetter

Date: 11/8/2021

Funding:
210.2130.0319.004.000.0273

Exhibit A

SCOPE OF WORK

Overall Strategy

1. Cost sharing for half time therapist to be embedded in Gladstone High School
2. Insurance blind services; OHP, Private, indigent, under-insured resources
3. Expedited access to services, co-location near school counselors
4. Services include staff communications, referral, mental health consults, mental illness assessments, treatment planning, therapy, follow-up, care-coordination & navigation with other supports for student well-being
5. Organizational learning from pilot project and District & County partnership.

Services Narrative

In partnership with the Gladstone High School, Clackamas Health Centers will provide a Mental/Behavioral Health (MH/BH) staff to be located at the High School approximately 2.5 days a week during the school year. The work they would be doing is three-fold; consultation/education for school counselors and staff, screening and coordination for students, and providing direct MH Therapy.

The consultation piece is related to the availability of the MH staff to the school staff, primarily school counselors, to discuss challenging cases, general approaches, and resources that can be used to support students. They will work in conjunction with staff on best approaches in a variety of school settings and with different teachers and providers. Education-wise, the MH staff could help present information alongside the health and wellness teachers around basic mental health, self-care, social-emotional supports and overall well-being.

Screenings and coordination could happen at the referral of a school counselor or principals to do brief screenings and interventions to help identify the best needs for the students and/or their families. School staff and MH staff to determine data collection needs for student well-being and pilot program efficacy; referrals conditions, services, etc.

Direct MH therapy would be available to those students and would benefit from such. This would include a mental health intake, treatment planning, and on-going treatment. This could also include group therapy if the need arises. This would be done when the circumstances are such that the student would be best served in the school setting.

Furthermore, the MH staff could then help provide bridge services until other connections are made with the appropriate outside provider or community resources. The MH staff could also be sure to incorporate the appropriate school staff as needed when screening for more high risk behaviors and higher levels of care.

Learning objectives from pilot project

Issues for shared inquiry during and at conclusion 2021-22 school year:

- Insurer support and other resources for co-located model outside community or school based health clinics?
- Cost sharing distribution among funders/payers and with non-billable services, under-insured students, family loads with co-pays and premiums, care-coordination & navigation. Mental Health flexible funds?
- Alignment of a school embedded therapist's functions with broader health, education, and insurer systems; Clackamas County Health Centers, Gladstone Culture of Care. Partnership value-add?
- Enhanced continuity of care for students; providers, clinics, service levels?
- Continuance, adjustments, upgrades for FY 22-23?

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Board of Commissioners
Clackamas County

Members of the Board:

Approval of Amendment #2 to a Grant Agreement with Clackamas Women's Services for Emergency Transitional Housing Services in the amount of $105,000 in County General Funds through the Affordable Housing and Services Fund

Purpose/Outcomes	Agency will provide emergency motel vouchers for low-income and high-risk households.
Dollar Amount and Fiscal Impact	$105,000 for Year 3, FY21-22
Funding Source	County General, Affordable Housing Services Fund.
Duration	Amendment is effective upon signature, with an eligible grant expenditure period of July 1, 2021 – June 30, 2022.
Previous Board Action/Review	The original agreement and amendment #1 were approved by the Board on 9-12-2019 and 10-8-2020. Board Issues date for Amendment #2: November 23, 2021
Strategic Plan Alignment	1. This funding aligns with the Social Services Division's strategic priority to provide housing stabilization and supportive services to people who are homeless or at risk of becoming homeless so they can obtain and maintain permanent housing. 2. This funding aligns with the County's strategic priority to ensure safe, healthy and secure communities.
Counsel Review	This Grant Amendment was reviewed and approved by County Counsel on 11-4-21 by KR.
Procurement Review	1. Was the item processed through Procurement? No 2. If no, provide brief explanation: This is a grant amendment, not subject to Procurement review.
Contact Person	Brenda Durbin, Social Services Director (503)655-8641
Contract No.	H3S# 9436

BACKGROUND:
The Social Services Division (SSD) of the Health, Housing, and Human Services Department requests the approval of Amendment #2 to a Grant Agreement with Clackamas Women's Services (CWS). CWS provides services for victims of domestic violence, and the funds will allow the agency to continue to administer a program that mitigates the risk of homelessness for

vulnerable members of the County through the provision of emergency motel vouchers for low-income and high-risk households.

The three-year contract maximum, if the optional renewal for the last year is approved, is $300,000. Based on the successful completion of grant outcomes during Year 1, the need to modify the length of vouchers based on Year 2, as well as funding availability from the County General, Affordable Housing Services Fund, the grant is being amended to authorize the option for the Year 3 renewal.

This Grant Amendment was approved by County Counsel and is effective upon signature by all parties. The eligible grant expenditure period is July 1, 2021 through June 30, 2022. The funding source is County General, Affordable Housing Services Fund.

RECOMMENDATION:
Staff recommends Board approval of this Grant Amendment and authorization for Tootie Smith, Board Chair, to sign.

Respectfully submitted,

Mary Rumbaugh

Rodney A. Cook, Director
Health, Housing and Human Services Department

Contract Amendment
Health, Housing and Human Services Department

H3S Contract Number 9436 Board Agenda Number TBD

and Date November 24, 2021

Division Social Services Amendment No. 2

Contractor **Clackamas Women's Services**

Amendment Requested By Brenda Durbin, Director

Changes:
- ☒ Scope of Services
- ☒ Contract Time
- ☐ Contract Budget
- ☒ Other Authorizes Year 3 extension

Justification for Amendment:

The County awarded a grant to Clackamas Women's Services (CWS) to provide services for victims of domestic violence, and administer a program that mitigates the risk of homelessness for vulnerable members of the County through the provision of emergency motel vouchers for low-income and high-risk households. Year 2 ended on June 30, 2021.

The grant agreement with CWS provides for two (2) additional one-year optional renewals until June 30, 2022, dependent on agency performance, and with the approval of Board of County Commissioners, for a $300,000 total contract maximum.

Due to unforeseen complications of the pandemic, Year 2 funding was not fully expended. To ensure Year 3 funding is fully expended, a modification is being requested, from authorizing 2 weeks per household to authorizing up to 4 weeks per household of emergency motel vouchering. One of the original intentions of the grant was to have survivors move out of shelter once they had housing secured, to free up more shelter beds. During the pandemic, CWS has been primarily using motel vouchering to provide shelter, and although they have increased the number of people served in the shelter program by over 50%, households rarely need less than 2 weeks of motel vouching, which is the criteria for the grant.

Based on the need to consider modifications to the grant outcomes, as well as funding availability from the County General, Affordable Housing Services Fund, the grant is being amended to authorize the option for the Year 3 renewal, to be effective upon signature, with an eligible grant expenditure period of July 1, 2021 to June 30, 2022 in the amount of $105,000.

Except as amended hereby, all other terms and conditions of the agreement remain in full force and effect. The County has identified the changes with ***"bold/italic"*** font for easy reference.

AMEND ARTICLE I., Effective Date and Duration, TO INCLUDE:

Based on Contractor's performance and outcomes of the original Grant Agreement term, County Authorizes Year 3 renewal option, Fiscal Year 2021-2022 in the amount of $105,000 as outlined in Article I, #3. Consideration and Exhibit A.

Year 3 eligible grant expenditure period is July 1, 2021 to June 30, 2022 as outlined in Exhibit A.

AMEND I. SCOPE OF WORK, TO READ:

Funding for this project will enhance Contractor's Shelter and Housing Program's ability to mitigate the risk of homelessness for vulnerable members of the county through the provision of emergency motel vouchers for approximately 85 low-income and high-risk households during ***Year 1 and Year 2 funding, and approximately 42 households in Year 3 of funding.***

AMEND II. PERFORMANCE OUTCOMES, PARAGRAPH B. TO READ:

B. Reported Outcomes for this Program
   I. Up to 85 households will be provided with two-week motel vouchers ***in each Year 1 and Year 2*** the project is funded; ***and approximately 42 households will be provided up to four-week motel vouchers in Year 3 of funding.***

AMEND III. COMPENSATION, PARAGRAPH I, TO READ:

I. Invoices shall be submitted to:
Clackamas County Social Services, email: caainvoices@clackamas.us

IN WITNESS WHEREOF, the parties hereto have caused this amendment to be executed by their duly authorized officers.

AGENCY

CLACKAMAS WOMEN'S SERVICES

By:

DocuSigned by:
DBCAD1860649464...

Melissa Erlbaum, Executive Director

11/7/2021
Date

256 Warner Milne Road
Street Address

Oregon City, Oregon 97045
City / State / Zip

(503) 655-8600 /
Phone / Fax

CLACKAMAS COUNTY

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

Tootie Smith, Chair Date

Approved as to Form:

Kathleen J. Rastetter

County Counsel 11/4/2021
Date

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Local Subrecipient Grant Agreement for Northwest Family Services to provide Family Resource Coordinators in Clackamas County Agreement is $149,119 funded through Oregon Early Learning Division and Clackamas County General Fund

Purpose/Outcome	Northwest Family Services (NWFS) will continue to provide Family Resource Coordinators (FRC's) to connect families with children ages 0-6, who experience barriers to school success, with holistic services that promote family stability, healthy child development, and school readiness. The FRC's will operate in the specified Health Equity Zone of Gladstone and Oregon City to receive, coordinate, and expedite service referrals for families to help them navigate healthcare, education, and other human service systems that facilitate family stability and access to necessary services.
Dollar Amount and Fiscal Impact	Agreement has a maximum value of $149,119 and terminates on December 31, 2022 Clackamas County General Funds are involved
Funding Source	State of Oregon, Dept of Education through its Early Learning Division ($49,119) and Clackamas County General Fund through its Children, Family & Community Connections Division ($100,000).
Duration	This amendment is effective October 1, 2021 for services ending December 31, 2022
Previous Board Action/Review	Board Issues Date: 11/23/21
Strategic Plan Alignment	1. Ensure safe, healthy and secure communities
Counsel Review	This Subrecipient Grant agreement has been reviewed and approved by County Counsel on 11/26/21 , KR
Procurement Review	Was the item processed through Procurement? No. Subrecipient selected through a competitive process
Contact Person	Adam Freer 971-533-4929
Contract No.	CFCC #10424

BACKGROUND:
The Children, Family & Community Connections Division of the Health, Housing and Human Services Department requests approval of a Local Subrecipient Grant Agreement with NWFS to continue to provide Family Resource Coordinators in the Health Equity Zones of Gladstone and Oregon City. NWFS was selected through a competitive process in 2019 to provide Family Resource Coordination in Clackamas County. The FRC coordinates referrals for families, prioritizing those whose children ages 0-6

experience barriers to school success, and follows-up with families and service providers to ensure timely access and assure that services have effectively met mutually identified needs.

This Local Subrecipient Grant Agreement is effective upon signature by all parties for services starting on October 1, 2021 and terminating on December 31, 2022. This Agreement has a maximum value of $149,119.

RECOMMENDATION:
Staff recommends the Board approval of this Agreement and authorization for Tootie Smith, Board Chair, to sign on behalf of Clackamas County.

Respectfully submitted,
Mary Rumbaugh
Rodney A. Cook, Director
Health, Housing & Human Services

CLACKAMAS COUNTY, OREGON LOCAL SUBRECIPIENT GRANT AGREEMENT CFCC- 10424 Program Name: ***Family Resource Coordination*** Program/Project Number: 10424	
This Agreement is between **Clackamas County, Oregon**, acting by and through its Health, Housing & Human Services Children, Family & Community Connections Division (COUNTY) and **Northwest Family Services** (SUBRECIPIENT), an Oregon Non-profit Organization.	
COUNTY Data	
Grant Accountant: Joseph Rosevear	Program Manager: Dani Stamm Thomas
Clackamas County Finance 2051 Kaen Road Oregon City, OR 97045 (503) 742-5429 jrosevear@clackamas.us	Children, Family & Community Connections 112 11th Street Oregon City, OR 97045 (971) 288-8264 dstammthomas@clackamas.us
SUBRECIPIENT Data	
Finance/Fiscal Representative: Rose Fuller	Program Representative: Jackie Vargas
Northwest Family Services 6200 SE King Rd Portland, OR 97222 rfuller@nwfs.org	Northwest Family Services 6200 SE King Rd Portland, OR 97222 jvargas@nwfs.org
FEIN: 93-0841022	

RECITALS

1. Northwest Family Services (SUBRECIPIENT), a local Nonprofit 501(c)(3) organization, was selected through a competitive process in 2019 to provide Family Resource Coordinators in Clackamas County. The Family Resource Coordinator operates in a specified Health Equity Zone to receive, coordinate, and expedite service referrals for families with children ages 0-6 to assist families in navigating healthcare, education, and other human services systems that facilitate family stability and access to necessary services

2. SUBRECIPIENT will refer and connect families with children ages 0-6, who experience barriers to school success, to holistic services that promote family stability, healthy child development, and school readiness.

3. This Agreement of financial assistance sets forth the terms and conditions pursuant to which SUBRECIPIENT agrees on delivery of the Program.

NOW THEREFORE, according to the terms of this Local SUBRECIPIENT Agreement, COUNTY and SUBRECIPIENT agree as follows:

AGREEMENT

1. **Term and Effective Date.** This Agreement shall become effective on the date it is fully executed and approved as required by applicable law. Funds issued under this Agreement may be used to reimburse SUBRECIPIENT for expenses approved in writing by County relating to the project incurred no earlier than **October 1, 2021** and not later than **December 31, 2022**, unless this Agreement is sooner terminated or extended pursuant to the terms hereof. No grant funds are available for expenditures after the expiration date of this Agreement.

2. **Program.** The Program is described in Attached Exhibit A: SUBRECIPIENT Scope of Work. SUBRECIPIENT agrees to perform the Program in accordance with the terms and conditions of this Agreement.

3. **Standards of Performance.** SUBRECIPIENT shall perform all activities and programs in accordance with the requirements set forth in this Agreement and all applicable laws and regulations. Furthermore, SUBRECIPIENT shall comply with the requirements of Clackamas County and the Oregon Early Learning Division HUB Grant Agreement.

4. **Grant Funds**. COUNTY's funding for this Agreement is Clackamas County **($100,000)** and the Oregon Early Learning Division HUB Coordination Grant (**$46,119**). The maximum, not to exceed, grant amount that COUNTY will pay on this Agreement is **$146,119.**

5. **Disbursements**. This is a cost reimbursement grant and disbursements will be made in accordance with the requirements contained in Exhibit D: Request for Reimbursement.

   Failure to comply with the terms of this Agreement may result in withholding of payment.

6. **Amendments.** The terms of this Agreement shall not be waived, altered, modified, supplemented, or amended, in any manner whatsoever, except by written instrument signed by both parties. **SUBRECIPIENT must submit a written request including a justification for any amendment to the COUNTY in writing at least forty five (45) calendar days before this Agreement expires.** No payment will be made for any services performed before the beginning date or after the expiration date of this Agreement. If the maximum compensation amount is increased by amendment, the amendment must be fully effective before SUBRECIPIENT performs work subject to the amendment.

7. **Termination.** This Agreement may be suspended or terminated prior to the expiration of its term by:
   a. Written notice provided by COUNTY resulting from material failure by SUBRECIPIENT to comply with any term of this Agreement, or;
   b. Mutual agreement by COUNTY and SUBRECIPIENT.
   c. Written notice provided by COUNTY that funds are no longer available for this purpose.

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

   Effect of Termination. The expiration or termination of this Agreement, for any reason, shall not release SUBRECIPIENT from any obligation or liability to COUNTY, or any requirement or obligation that:
   d. Has already accrued hereunder;
   e. Comes into effect due to the expiration or termination of the Agreement; or
   f. Otherwise survives the expiration or termination of this Agreement.

   Following the termination of this Agreement, SUBRECIPIENT shall promptly identify all unexpended funds and return all unexpended funds to COUNTY. Unexpended funds are those funds received

by SUBRECIPIENT under this Agreement that (i) have not been spent or expended in accordance with the terms of this Agreement; and (ii) are not required to pay allowable costs or expenses that will become due and payable as a result of the termination of this Agreement

8. **Funds Available and Authorized.** COUNTY certifies that it has been awarded funds sufficient to finance the costs of this Agreement. SUBRECIPIENT understands and agrees that payment of amounts under this Agreement is contingent on COUNTY receiving appropriations or other expenditure authority sufficient to allow COUNTY, in the exercise of its reasonable administrative discretion, to continue to make payments under this Agreement.

9. **Future Support.** COUNTY makes no commitment of future support and assumes no obligation for future support for the activity contracted herein except as set forth in this agreement.

10. **Nonprofit status.** SUBRECIPIENT warrants that it is, and shall remain during the performance of this Agreement, a private nonprofit Organization as defined in the Regulations, including:
    a. That it is described in Section 501(c) of the Internal Revenue Code of 1954;
    b. That it is exempt from taxation under Subtitle A of the Internal Revenue Code of 1954;
    c. That it has an accounting system and a voluntary board; and
    d. That it practices nondiscrimination in the provision of its services.

11. **Administrative Requirements**. SUBRECIPIENT agrees to its status as a SUBRECIPIENT, and accepts among its duties and responsibilities the following:

    a) **Financial Management.** SUBRECIPIENT shall comply with Generally Accepted Accounting Principles (GAAP) or another equally accepted basis of accounting, use adequate internal controls, and maintain necessary sources documentation for all costs incurred.

    b) **Revenue Accounting.** Grant revenue and expenses generated under this Agreement should be recorded in compliance with generally accepted accounting principles and/or governmental accounting standards. This requires that the revenues are treated as unearned income or "deferred" until the compliance requirements and objectives of the grant have been met. Revenue may be recognized throughout the life cycle of the grant as the funds are "earned". All grant revenues not fully earned and expended in compliance with the requirements and objectives at the end of the period of performance must be returned to the County within 15 days.

    c) **Budget.** SUBRECIPIENT use of funds may not exceed the amounts specified in the Exhibit B: SUBRECIPIENT Program Budget. SUBRECIPIENT agrees to expend funds in accordance with the approved budget provided in this agreement. All expenditures that exceed a budget line item by more than 10% or $500, whichever is greater, must be approved in writing by COUNTY. Budget revisions must be submitted and approved prior to changing the budget. At no time may budget modifications change the scope of the original grant application or agreement.

    d) **Allowable Uses of Funds**. SUBRECIPIENT shall use funds only for those purposes authorized in this Agreement and in accordance with Clackamas County and Oregon Early Learning Division.

    e) **Period of Availability.** SUBRECIPIENT may charge to the award only allowable costs resulting from obligations incurred during the term and effective date. Cost incurred prior or after this date will be disallowed.

    f) Match. Matching funds are not required for this Agreement.

g) **Payment.** Routine requests for reimbursement should be submitted monthly by the 15th of the following month using the form and instructions in Exhibit D: Request for Reimbursement. SUBRECIPIENT must submit a final request for payment no later than fifteen (15) days after the end date of this Agreement.

h) **Performance and Financial Reporting.** SUBRECIPIENT must submit Performance Reports according to the schedule specified in Exhibit C: SUBRECIPIENT Performance Reporting. SUBRECIPIENT must submit Financial Reports according to the schedule specified in Exhibit D: Request for Reimbursement. All reports must be signed and dated by an authorized official of SUBRECIPIENT.

i) **Audit**. SUBRECIPIENT shall comply with the audit requirements prescribed by State and Federal law.

j) **Monitoring.** SUBRECIPIENT agrees to allow access to conduct site visits and inspections of financial and programmatic records for the purpose of monitoring. COUNTY, and its duly authorized representatives shall have access to such records and other books, documents, papers, plans, records of shipments and payments and writings of SUBRECIPIENT that are pertinent to this Agreement, whether in paper, electronic or other form, to perform examinations and audits and make excerpts, copies and transcripts. Monitoring may be performed onsite or offsite, at COUNTY's discretion.

k) **Record Retention**. SUBRECIPIENT will retain and keep accessible all such financial records, books, documents, papers, plans, records of shipments and payments and writings for a minimum of six (6) years following the Project End Date (June 30, 2021), or such longer period as may be required by applicable law, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever date is later.

l) **Failure to Comply.** SUBRECIPIENT acknowledges and agrees that this agreement and the terms and conditions therein are essential terms in allowing the relationship between COUNTY and SUBRECIPIENT to continue, and that failure to comply with such terms and conditions represents a material breach of the original contract and this agreement. Such material breach shall give rise to COUNTY's right, but not obligation, to withhold SUBRECIPIENT grant funds until compliance is met, reclaim grant funds in the case of omissions or misrepresentations in financial or programmatic reporting, or to terminate this relationship including the original contract and all associated amendments.

12. **Compliance with Applicable Laws**

a) **Public Policy**. SUBRECIPIENT expressly agrees to comply with all public policy requirements, laws, regulations, and executive orders issued by the Federal government, to the extent they are applicable to the Agreement: (i) Titles VI and VII of the Civil Rights Act of 1964, as amended; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Americans with Disabilities Act of 1990, as amended; (iv) Executive Order 11246, as amended; (v) the Health Insurance Portability and Accountability Act of 1996; (vi) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (vii) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (viii) all regulations and administrative rules established pursuant to the foregoing laws; and (ix) all other applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations; and as applicable to SUBRECIPIENT.

b) **State Statutes**. SUBRECIPIENT expressly agrees to comply with all statutory requirements, laws, rules, and regulations issued by the State of Oregon, to the extent they are applicable to the agreement.

c) **Conflict Resolution.** If conflicts are discovered among federal, state and local statutes, regulations, administrative rules, executive orders, ordinances and other laws applicable to the Services under the Agreement, SUBRECIPIENT shall in writing request COUNTY resolve the conflict. SUBRECIPIENT shall specify if the conflict(s) create a problem for the design or other Services required under the Agreement.

General Agreement Provision

a) **Non-appropriation Clause.** If payment for activities and programs under this Agreement extends into COUNTY's next fiscal year, COUNTY's obligation to pay for such work is subject to approval of future appropriations to fund the Agreement by the Board of County Commissioners.

b) **Indemnification.** SUBRECIPIENT agrees to indemnity and hold COUNTY harmless with respect to any claim, cause, damage, action, penalty or other cost (including attorney's and expert fees) arising from or related to SUBRECIPIENT's negligent or willful acts or those of its employees, agents or those under SUBRECIPIENT's control. SUBRECIPIENT is responsible for the actions of its own agents and employees, and COUNTY assumes no liability or responsibility with respect to SUBRECIPIENT's actions, employees, agents or otherwise with respect to those under its control.

c) **Insurance**. During the term of this agreement, SUBRECIPIENT shall maintain in force, at its own expense, each insurance noted below:

1) **Commercial General Liability**. SUBRECIPIENT shall obtain, at SUBRECIPIENT's expense, and keep in effect during the term of this agreement, Commercial General Liability Insurance covering bodily injury, death, and property damage on an "occurrence" form in the amount of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate for the protection of COUNTY, its officers, commissioners, and employees. This coverage shall include Contractual Liability insurance for the indemnity provided under this agreement. This policy(s) shall be primary insurance as respects to COUNTY. Any insurance or self-insurance maintained by COUNTY shall be excess and shall not contribute to it.

2) **Commercial Automobile Liability**. If the Agreement involves the use of vehicles, SUBRECIPIENT shall obtain at SUBRECIPIENT expense, and keep in effect during the term of this agreement, Commercial Automobile Liability coverage including coverage for all owned, hired, and non-owned vehicles. The combined single limit per occurrence shall not be less than $1,000,000.

3) **Professional Liability**. If the Agreement involves the provision of professional services, SUBRECIPIENT shall obtain and furnish COUNTY evidence of Professional Liability Insurance covering any damages caused by an error, omission, or negligent act related to the services to be provided under this agreement, with limits not less than $2,000,000 per occurrence for the protection of COUNTY, its officers, commissioners and employees against liability for damages because of personal injury, bodily injury, death, or damage to property, including loss of use thereof, and damages because of negligent acts, errors and omissions in any way related to this agreement. COUNTY, at its option, may require a complete copy of the above policy.

4) **Workers' Compensation.** Insurance in compliance with ORS 656.017, which requires all employers that employ subject workers, as defined in ORS 656.027, to provide workers' compensation coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). If contractor is a subject employer, as defined

in ORS 656.023, contractor shall obtain employers' liability insurance coverage limits of not less than $1,000,000.

5) **Additional Insured Provisions**. All required insurance, other than Professional Liability, Workers' Compensation, and Personal Automobile Liability and Pollution Liability Insurance, shall include "Clackamas County, its agents, officers, and employees" as an additional insured, as well as the but only with respect to SUBRECIPIENT's activities under this agreement.

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

7) **Notice of Cancellation.** There shall be no cancellation, material change, exhaustion of aggregate limits or intent not to renew insurance coverage without 30 days written notice to the COUNTY. Any failure to comply with this provision will not affect the insurance coverage provided to COUNTY. The 30 day notice of cancellation provision shall be physically endorsed on to the policy.

8) **Insurance Carrier Rating**. Coverage provided by SUBRECIPIENT must be underwritten by an insurance company deemed acceptable by COUNTY. Insurance coverage shall be provided by companies admitted to do business in Oregon or, in the alternative, rated A- or better by Best's Insurance Rating. COUNTY reserves the right to reject all or any insurance carrier(s) with an unacceptable financial rating.

9) **Certificates of Insurance.** As evidence of the insurance coverage required by this agreement, SUBRECIPIENT shall furnish a Certificate of Insurance to COUNTY. No agreement shall be in effect until the required certificates have been received, approved, and accepted by COUNTY. A renewal certificate will be sent to COUNTY 10 days prior to coverage expiration.

10) **Primary Coverage Clarification**. SUBRECIPIENT coverage will be primary in the event of a loss and will not seek contribution from any insurance or self-insurance maintained by, or provided to, the additional insureds listed above.

11) **Cross-Liability Clause**. A cross-liability clause or separation of insured's condition will be included in all general liability, professional liability, and errors and omissions policies required by the agreement.

Waiver of Subrogation. SUBRECIPIENT agrees to waive their rights of subrogation arising from the

work performed under this Agreement.

a) **Assignment.** SUBRECIPIENT shall not enter into any subcontracts or subawards for any of the Program activities required by the Agreement without prior written approval. This Agreement may not be assigned in whole or in part with the express written approval of COUNTY.

b) **Independent Status.** SUBRECIPIENT is independent of COUNTY and will be responsible for any federal, state, or local taxes and fees applicable to payments hereunder. SUBRECIPIENT is not an agent of COUNTY and undertakes this work independent from the control and direction of COUNTY excepting as set forth herein. SUBRECIPIENT shall not seek or have the power to bind COUNTY in any transaction or activity.

c) **Notices.** Any notice provided for under this Agreement shall be effective if in writing and (1) delivered personally to the addressee or deposited in the United States mail, postage paid, certified mail, return receipt requested, (2) sent by overnight or commercial air courier (such as Federal Express), (3) sent by facsimile transmission, with the original to follow by regular mail; or, (4) sent by electronic mail with confirming record of delivery confirmation through electronic mail return-receipt, or by confirmation that the electronic mail was accessed, downloaded, or printed. Notice will be deemed to have been adequately given three days following the date of mailing, or immediately if personally served. For service by facsimile or by electronic mail, service will be deemed effective at the beginning of the next working day.

d) **Governing Law.** This Agreement is made in the State of Oregon, and shall be governed by and construed in accordance with the laws of that state. Any litigation between COUNTY and SUBRECIPIENT arising under this Agreement or out of work performed under this Agreement shall occur, if in the state courts, in the Clackamas County court having jurisdiction thereof, and if in the federal courts, in the United States District Court for the State of Oregon.

e) **Severability**. If any provision of this Agreement is found to be illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the provision shall be stricken.

f) **Counterparts.** This Agreement may be executed in any number of counterparts, all of which together will constitute one and the same agreement. Facsimile copy or electronic signatures shall be valid as original signatures.

g) **Third Party Beneficiaries**. Except as expressly provided in this Agreement, there are no third party beneficiaries to this Agreement. The terms and conditions of this Agreement may only be enforced by the parties.

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

i) **Integration**. This agreement contains the entire agreement between COUNTY and SUBRECIPIENT and supersedes all prior written or oral discussions or agreements.

SUBRECIPIENT
Northwest Family Services
6200 SE King Rd
Portland, OR 97222

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

By: _____
Rose Fuller, Executive Director

Dated: 11/3/2021

By: _____
Tootie Smith, Board Chair
Clackamas County

Dated: _____

- Exhibit A-1: Scope of Work
- Exhibit A-2: Work Plan Quarterly Report
- Exhibit B: Program Budget
- Exhibit C: Quarterly Demographic Report
- Exhibit D-1: Request for Reimbursement
- Exhibit D-2: Monthly Activity Report

EXHIBIT A-1
SCOPE OF WORK

Contractor shall provide Family Resource Coordination Services ("Work") as described in this Exhibit A-1 and A-2.

The Early Learning Hub of Clackamas County receives its funding from the State of Oregon's Early Learning Division whose mission it is *"to support all of Oregon's young children and families to learn and thrive. We value equity v. making a positive impact for children and .families, dedication, integrity and collective wisdom to ben /it Oregon children and families"*.

Our local Hub aligns with the State in its daily operations by working as an integrated team focused on: Child Care, Early Learning Programs and Cross Systems Integration, Policy and Research, and Equity.

A primary strategy of our Hub is to strengthen the comprehensive Family Resource Coordination system that places Family Resource Coordinators in targeted Health Equity Zones to create optimal access to quality programming. Health Equity Zones in Clackamas County include:

1. Gladstone
2. Oregon City

Program Goals

The Family Resource Coordinator (FRC) is responsible for coordinating resources and services for families with children ages 0-6 prioritizing those who experience barriers to school success, in order to meet comprehensive Kindergarten Readiness goals including cognitive, language/literacy, social/emotional, behavioral, motor skills, health and well-being. The FRC operates in a specified Health Equity Zone to receive, coordinate, and expedite service referrals for families and help them navigate healthcare, education, and other human service systems. The FRC follows-up with families and service providers to ensure timely access and assure that services have effectively met mutually identified needs.

FRC primary tasks and goals Work include:

1. Being knowledgeable about early childhood development, childhood trauma, Adverse Childhood Experiences (ACEs), transitions, kindergarten readiness, impact of social determinants of health, and other risk factors, as well as the available service/referral options to meet each family's needs.
2. Building formal agreements with other family service providers, such as medical providers, educators, home visitors, school counselors, peer mentors, OHS Case Workers, parent coaches, and others to facilitate seamless referral and access to these services for families.
3. Accepting referrals from parents, school districts, early childhood providers, health providers, human and social service providers, and other child-serving entities.
4. Meeting with referred families to establish a menu of mutually agreed upon service and referral priorities.
5. Monitoring progress and timely follow-up with families to eliminate barriers to accessing recommended services.

6. Facilitating family's access to appropriate health and early childhood systems of screening and assessment (child development, medical, dental, mental health including childhood trauma and toxic stress, kindergarten readiness, and risk factors, etc.).
7. Utilizing Early Learning Hub required database platform to enter and track all client data, contacts, referrals and outcomes, on a continual basis, as work with clients occurs.
8. Participating in multi-specialist staffing sessions for struggling families with multiple destabilizing problems and utilizing multi-specialist teams such as Teacher Assistance Teams and Youth Services Teams.
9. Document comprehensive information about community resources through networks, databases, and partnership opportunities. Utilize and teach families to use Information & Referral tools such as 211, BabyLink, Help Me Grow, and Child Care Resource & Referral. Develop a menu of frequently needed services including, but not limited to basic needs, support groups, vocational development, parents supports and education, mentors, tutors, and social/emotional counseling and support
10. Submit monthly and quarterly reports and invoices as requested via the Clackamas County required reporting database and/or paper reports as requested.

EXHIBIT A-2

Work Plan and Quarterly Report

Clackamas County Children, Family & Community Connections Division
Early Learning Hub of Clackamas County
Work Plan and Quarterly Report

Early Learning Hub
OF CLACKAMAS COUNTY

Provider: Northwest Family Services
Program: Family Resource Coordination
Quarter:
Reporting Period: October 1, 2021– December 31, 2022

Hub Goals:

1. Aligned, coordinated, and family-centered early childhood system
2. Children are supported to enter school ready to succeed
3. Families are healthy, stable and attached

Activities/Outputs	Intermediate Outcomes/Measurement Tool		Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022	Oct-Dec 2022			
By Dec 31, 2022, 200 Families with children (0-6) will be referred and connected to holistic services that promote family stability, healthy child development, and school readiness.	**85% of families** are referred to school staff, family advocates, home visitors, early childhood specialists, behavioral health, and employment specialists.	# Families referred								
		# Families Successfully Connected								
	85% of families will complete early childhood screening and assessments (Developmental, medical, dental, vision, hearing, etc).	# Families referred for screening/ assessments								
		# Families completing screening/ assessments								
	85% of families will be referred to a pediatrician, establish a medical/dental home, insurance enrollment support, and will be offered other health services that promote resiliency and increase protective factors.	# Families referred								
		# Families Successfully Connected								
By Dec 31, 2022, Program participants will receive a minimum of **4** contacts, one of which will be face to face. *Contact is defined as*: face to face, phone call, email, or texting.	**85% of families** will follow through with mutually agreed upon referrals: assessments, treatment options, and family requested supports.	# Families Served								
		# Successful Follow Through on Plans								
By Dec 31, 2022, 150 families will be educated to use Information and Referrals systems i.e. 211info, BabyLink, CCR&R, TriMet Ride, IMATCH, Help Me Grow, etc.	**85% of parents** report that they know how to use I&R systems	# Families Served								
		# Families that report knowing how to use I&R services								
By Dec 31, 2022, all parents served by FRC will receive information on school/ kindergarten readiness, transition to school, literacy, and social/emotional development.	**100%** of families served by FRC will receive kindergarten readiness, successful transitions, literacy, and social emotional development information.	# Families Served								
List Schools, Districts, Community Based Organizations, medical providers, etc. that participated in planning/implementation/ongoing support and referrals of FRC work:										
List community meetings attended during the reporting period:										

Early Learning Hub
OF CLACKAMAS COUNTY

Children, Family and Community Connections Division
Early Learning Hub of Clackamas County
Family Resource Coordination
Work Plan 2021-2022
Comments and Narrative

Provider/ Location:
Quarter:

1. Provide detailed information to explain the numbers and activities reported in the work plan above.

    a. General project information:

    b. Professional Development Activities:

    c. Family Focused Activities:

    d. Child Focused Activities:

2. What are your **successes** this quarter, and what are some of the most impactful practices that your organization has implemented as a result of this project?

3. What **challenges** have you experienced this quarter?

    Family Success Stories:

FRC Reporting Requirements

Monthly report, general ledger and reimbursement request

- No later than the 15th of every month
- Reports go to: Dani Stamm Thomas dstammthomas@clackamas.us
- All reports need to CC: Chelsea Hamilton Chamilton@clackamas.us and Stephanie Radford SRadford@clackamas.us

Quarterly Report, Client Satisfaction Surveys and Demographic Data Forms due:

- Oct-Dec **Due January 15, 2022**
- Jan-Mar **Due April 16, 2022**
- April-June **Due July 16, 2022**
- July-Sept **Due October 15, 2022**
- Oct-Dec **Due January 15, 2023**

Client Satisfaction Surveys

Clackamas County's initiative to measure client satisfaction with direct services provided or funded by the county (if applicable).

Exhibit B: Budget

Contractor: Northwest Family Services
Program: Family Resource Coordinator
Address: 6200 SE King Rd
Portland, OR 97222
Contact Person: Jackie Vargas
Phone Number:
E-mail:

FRC

Contract #:
Contract Term: 10/1/21-12/31/22

Budget Category	Approved Budget 10/1/21-12/31/22		Total Budget
Personnel			
Family Resource Coordinator 1fte @ 40,560	$ 50,700.00	$ -	$ 50,700.00
Family Resource Coordinator 1fte @ 38,480	$ 48,105.00	$ -	$ 48,105.00
Supervision (.10 fte @ 58,000)	$ 7,250.00	$ -	$ 7,250.00
Fringe	$ 27,191.00	$ -	$ 27,191.00
			$ -
	$ 133,246.00	**$ -**	**$ 133,246.00**
Administration			
Admin	$ 11,992.00	$ -	$ 11,992.00
	$ 11,992.00	**$ -**	**$ 11,992.00**
Program costs			
Materials/Supplies	$ -	$ -	$ -
Mileage	$ 881.00	$ -	$ 881.00
Additional (please specify)			
	$ -	$ -	$ -
	$ 881.00	**$ -**	**$ 881.00**
Total Budget	**$ 146,119.00**	**$ -**	**$ 146,119.00**

EXHIBIT C: Quarterly Demographic Report

Quarterly Demographics Report														
Program: FRC Gladstone	**Provider: NWFS**													
Race/Ethnicity	**Program Participants Served**													
• *Participants should be counted in one category of race/ethnicity.* • *Participants that identify as multi-racial should be counted in that category and the particular racial mix should be included in a narrative.*	First quarter count ALL clients as new													**TOTAL SERVED YTD**
	Oct-Dec 21	Jan-Mar 22			Apr-Jun 22			July-Sep 22			Oct-Dec 22			
		NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	
American Indian and Alaska Native														
American Indian														0
Alaska Native														0
Canadian Inuit, Metis or First Nation *(please identify in narrative)*														0
Asian														0
Chinese														0
Vietnamese														0
Korean														0
Laotian														0
Filipino														0
Japanese														0
South Asian														0
Asian Indian														0
Other Asian *(please identify in narrative)*														0
Black/African American														
African American														0
African														0
Caribbean														0
Other Black *(please identify in narrative)*														0
Hispanic or Latino														
Hispanic or Latino Mexican														0
Hispanic or Latino Central American														0
Hispanic or Latino South American														0
Other Hispanic or Latino *(please identify in narrative)*														0
Indigenous Mexican, Central American or South American *(please identify)*														0
Pacific Islander														
Native Hawaiian														0
Guamanian or Chamorro														0
Samoan														0
Other Pacific Islander *(please identify in narrative)*														0
White														0
Slavic														0
Middle Eastern														0
North African														0
Multi-Racial *(please identify in narrative)*														0
Decline to Answer														0
Unknown														0
TOTAL BY RACE/ETHNICITY	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Primary Language														
Cantonese														0
English														0
Russian														0
Spanish														0
Ukranian														0
Vietnamese														0
Other *(list language in narrative)*														0
TOTAL BY LANGUAGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gender Identification														
Female														0
Male														0
Transgender														0
Unknown or Declined to Say														0
TOTAL BY GENDER	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Age														
0-6														0
7-12														0
13-17														0
18-24														0
25-59														0
60+														0
Unknown or Declined														0
TOTAL BY AGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Race/Ethnicity **TOTAL**, *Gender* **TOTAL** *and Age TOTALs should match.*														

Quarterly Demographics Report														
Program: FRC Oregon City	**Provider: NWFS**													
Race/Ethnicity	**Program Participants Served**													
• *Participants should be counted in one category of race/ethnicity.* • *Participants that identify as multi-racial should be counted in that category and the particular racial mix should be included in a narrative.*	First quarter count ALL clients as new													**TOTAL SERVED YTD**
	Oct-Dec 21	Jan-Mar 22			Apr-Jun 22			July-Sep 22			Oct-Dec 22			
		NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	
American Indian and Alaska Native														
American Indian														0
Alaska Native														0
Canadian Inuit, Metis or First Nation *(please identify in narrative)*														0
Asian														0
Chinese														0
Vietnamese														0
Korean														0
Laotian														0
Filipino														0
Japanese														0
South Asian														0
Asian Indian														0
Other Asian *(please identify in narrative)*														0
Black/African American														
African American														0
African														0
Caribbean														0
Other Black *(please identify in narrative)*														0
Hispanic or Latino														
Hispanic or Latino Mexican														0
Hispanic or Latino Central American														0
Hispanic or Latino South American														0
Other Hispanic or Latino *(please identify in narrative)*														0
Indigenous Mexican, Central American or South American *(please identify)*														0
Pacific Islander														
Native Hawaiian														0
Guamanian or Chamorro														0
Samoan														0
Other Pacific Islander *(please identify in narrative)*														0
White														0
Slavic														0
Middle Eastern														0
North African														0
Multi-Racial *(please identify in narrative)*														0
Decline to Answer														0
Unknown														0
TOTAL BY RACE/ETHNICITY	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Primary Language														
Cantonese														0
English														0
Russian														0
Spanish														0
Ukranian														0
Vietnamese														0
Other *(list language in narrative)*														0
TOTAL BY LANGUAGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gender Identification														
Female														0
Male														0
Transgender														0
Unknown or Declined to Say														0
TOTAL BY GENDER	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Age														
0-6														0
7-12														0
13-17														0
18-24														0
25-59														0
60+														0
Unknown or Declined														0
TOTAL BY AGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Race/Ethnicity TOTAL, Gender TOTAL and Age TOTALs should match														

EXHIBIT D-1: REIMBURSEMENT REQUEST

Exhibit D-1: REQUEST FOR REIMBURSEMENT

Requests for reimbursement and supporting documentation are due monthly by the 15th of the month, including:
- Request for Reimbursement with an authorized signature
- General Ledger backup to support the requested amount
- Monthly Activity Report (Exhibit D-2) showing numbers served and activities conducted during the month of request *(The Monthly Activity Report is NOT required on months when quarterly reports are due).*

Contractor: Northwest Family Services
Address: 6200 SE King Rd
Portland, OR 97222
Contact Person: Jackie Vargas
Contact Info:
Term: 10/1/21-12/31/22

Contract Number:

Report Period:

FRC

Budget Category	Approved Budget (10/1/21-12/31/22)	Current Draw Request	Previously Requested	Balance
Personnel				
Family Resource Coordinator 1fte @ 40,560	$ 50,700.00	$ -	$ -	$ 50,700.00
Family Resource Coordinator 1fte @ 38,480	$ 48,105.00	$ -	$ -	$ 48,105.00
Supervision (.10 fte @ $58k)	$ 7,250.00	$ -	$ -	$ 7,250.00
Fringe	$ 27,191.00	$ -	$ -	$ 27,191.00
	$ 133,246.00	**$ -**	**$ -**	**$ 133,246.00**
Administration				
Admin	$ 11,992.00	$ -	$ -	$ 11,992.00
	$ 11,992.00	**$ -**	**$ -**	**$ 11,992.00**
Program costs				
Materials/Supplies	$ -	$ -	$ -	$ -
Mileage	$ 881.00	$ -	$ -	$ 881.00
Additional (please specify)				
	$ -	$ -	$ -	$ -
	$ 881.00	**$ -**	**$ -**	**$ 881.00**
Total Budget	**$ 146,119.00**	**$ -**	**$ -**	**$ 146,119.00**

Clackamas County retains the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of Recipient that are pertinent to this Agreement.

CERTIFICATION

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and represents actual expenditures, disbursements and cash receipts for the purposes and objectives set forth in the terms of the agreement.

EXHIBIT D-2: MONTHLY ACTIVITY REPORT

Agency: Northwest Family Services
Funded Service: Family Resource Coordinator
Program Contact:
Month:

This report covers the fiscal year starting ***October 1, 2021 through December 31, 2022.*** *Complete the sections below as they apply to the group(s) targeted for services with this funding as outlined in your Work Plan.*

Submit this report with monthly requests for reimbursement except on months when the quarterly report is submitted.

1. **Total number of participants served during the month with the funding allocated for this programming:**

   Number of children:
   Number of Families:

2. **Activities that were conducted during the month with the funding allocated for this programming:**

3. **Issues related to service delivery and how those issues were addressed.**

Person(s) completing this form:
Date:

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Local Subrecipient Grant Agreement for Metropolitan Family Services to provide Family Resource Coordinators in Clackamas County Agreement is $149,119 funded through Oregon Early Learning Division No County General Funds are involved

Purpose/Outcome	Metropolitan Family Resources will continue to provide Family Resource Coordinators (FRC's) to connect families with children ages 0-6, who experience barriers to school success, with holistic services that promote family stability, healthy child development, and school readiness. The FRC's will operate in the specified Health Equity Zone in North Clackamas County to receive, coordinate, and expedite service referrals for families to help them navigate healthcare, education, and other human service systems that facilitate family stability and access to necessary services.
Dollar Amount and Fiscal Impact	Agreement has a maximum value of $149,119 and terminates on December 31, 2022 No County Funds are involved
Funding Source	State of Oregon, Dept of Education through its Early Learning Division
Duration	This amendment is effective October 1, 2021 for services ending December 31, 2022
Previous Board Action/Review	Board Issues Date: 11/23/21
Strategic Plan Alignment	1. Ensure safe, healthy and secure communities
Counsel Review	This Subrecipient Grant agreement has been reviewed and approved by County Counsel on 11/3/21 , KR
Procurement Review	Was the item processed through Procurement? No. Subrecipient selected through a competitive process
Contact Person	Adam Freer 971-533-4929
Contract No.	CFCC #10423

BACKGROUND:
The Children, Family & Community Connections Division of the Health, Housing and Human Services Department requests approval of a Local Subrecipient Grant Agreement with MFS to continue to provide Family Resource Coordinators in the Health Equity Zones of North Clackamas County. MFS was selected through a competitive process in 2019 to provide Family Resource Coordination in Clackamas County. The FRC coordinates referrals for families, prioritizing those whose children ages 0-6 experience barriers to school success, and follows-up with families and service providers to ensure timely access and assure that services have effectively met mutually identified needs.

This Local Subrecipient Grant Agreement is effective upon signature by all parties for services starting on October 1, 2021 and terminating on December 31, 2022. This Agreement has a maximum value of $149,119.

RECOMMENDATION:
Staff recommends the Board approval of this Agreement and authorization for Tootie Smith, Board Chair, to sign on behalf of Clackamas County.

Respectfully submitted,
Mary Rumbaugh
Rodney A. Cook, Director
Health, Housing & Human Services

CLACKAMAS COUNTY, OREGON **LOCAL SUBRECIPIENT GRANT AGREEMENT CFCC- H3S10423** Program Name: ***Family Resource Coordination*** Program/Project Number: 10423	
This Agreement is between **Clackamas County, Oregon**, acting by and through its Health, Housing & Human Services Children, Family & Community Connections Division (COUNTY) and **Metropolitan Family Services** (SUBRECIPIENT), an Oregon Non-profit Organization.	
COUNTY Data	
Grant Accountant: Joseph Rosevear	Program Manager: Dani Stamm Thomas
Clackamas County Finance 2051 Kaen Road Oregon City, OR 97045 (503) 742-5429 jrosevear@clackamas.us	Children, Family & Community Connections 112 11th Street Oregon City, OR 97045 (971) 288-8264 dstammthomas@clackamas.us
SUBRECIPIENT Data	
Finance/Fiscal Representative: Fay Allison	Program Representative: Meghan Zook
Metropolitan Family Services 1808 SE Belmont Portland, OR 97214 faya@mfs.email	Metropolitan Family Services 1808 SE Belmont Portland, OR 97214 meganz@mfs.email
FEIN: 93-0397825	

RECITALS

1. Metropolitan Family Services (SUBRECIPIENT), a local Nonprofit 501(c)(3) organization, was selected through a competitive process in 2019 to provide Family Resource Coordinators in North Clackamas County. The Family Resource Coordinator operates in a specified Health Equity Zone to receive, coordinate, and expedite service referrals for families with children ages 0-6 to assist families in navigating healthcare, education, and other human services systems that facilitate family stability and access to necessary services

2. SUBRECIPIENT will refer and connect families with children ages 0-6 who experience barriers to school success, to holistic services that promote family stability, healthy child development, and school readiness.

3. This Agreement of financial assistance sets forth the terms and conditions pursuant to which SUBRECIPIENT agrees on delivery of the Program.

NOW THEREFORE, according to the terms of this Local SUBRECIPIENT Agreement, COUNTY and SUBRECIPIENT agree as follows:

AGREEMENT

1. **Term and Effective Date.** This Agreement shall become effective on the date it is fully executed and approved as required by applicable law. Funds issued under this Agreement may be used to reimburse SUBRECIPIENT for expenses approved in writing by County relating to the project incurred no earlier than **October 1, 2021** and not later than **December 31, 2022**, unless this Agreement is sooner terminated or extended pursuant to the terms hereof. No grant funds are available for expenditures after the expiration date of this Agreement.

2. **Program.** The Program is described in Attached Exhibit A: SUBRECIPIENT Scope of Work. SUBRECIPIENT agrees to perform the Program in accordance with the terms and conditions of this Agreement.

3. **Standards of Performance.** SUBRECIPIENT shall perform all activities and programs in accordance with the requirements set forth in this Agreement and all applicable laws and regulations. Furthermore, SUBRECIPIENT shall comply with the requirements of the Oregon Early Learning Division HUB Grant Agreement.

4. **Grant Funds**. COUNTY's funding for this Agreement is Oregon Early Learning Division HUB Coordination Grant (**$146,119**). The maximum, not to exceed, grant amount that COUNTY will pay on this Agreement is **$146,119.**

5. **Disbursements**. This is a cost reimbursement grant and disbursements will be made in accordance with the requirements contained in Exhibit D: Request for Reimbursement.

   Failure to comply with the terms of this Agreement may result in withholding of payment.

6. **Amendments.** The terms of this Agreement shall not be waived, altered, modified, supplemented, or amended, in any manner whatsoever, except by written instrument signed by both parties. **SUBRECIPIENT must submit a written request including a justification for any amendment to the COUNTY in writing at least forty five (45) calendar days before this Agreement expires.** No payment will be made for any services performed before the beginning date or after the expiration date of this Agreement. If the maximum compensation amount is increased by amendment, the amendment must be fully effective before SUBRECIPIENT performs work subject to the amendment.

7. **Termination.** This Agreement may be suspended or terminated prior to the expiration of its term by:
   a. Written notice provided by COUNTY resulting from material failure by SUBRECIPIENT to comply with any term of this Agreement, or;
   b. Mutual agreement by COUNTY and SUBRECIPIENT.
   c. Written notice provided by COUNTY that funds are no longer available for this purpose.

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

   Effect of Termination. The expiration or termination of this Agreement, for any reason, shall not release SUBRECIPIENT from any obligation or liability to COUNTY, or any requirement or obligation that:
   d. Has already accrued hereunder;
   e. Comes into effect due to the expiration or termination of the Agreement; or
   f. Otherwise survives the expiration or termination of this Agreement.

   Following the termination of this Agreement, SUBRECIPIENT shall promptly identify all unexpended funds and return all unexpended funds to COUNTY. Unexpended funds are those funds received by SUBRECIPIENT under this Agreement that (i) have not been spent or expended in accordance with the terms of this Agreement; and (ii) are not required to pay allowable costs or expenses that

will become due and payable as a result of the termination of this Agreement

8. **Funds Available and Authorized.** COUNTY certifies that it has been awarded funds sufficient to finance the costs of this Agreement. SUBRECIPIENT understands and agrees that payment of amounts under this Agreement is contingent on COUNTY receiving appropriations or other expenditure authority sufficient to allow COUNTY, in the exercise of its reasonable administrative discretion, to continue to make payments under this Agreement.

9. **Future Support.** COUNTY makes no commitment of future support and assumes no obligation for future support for the activity contracted herein except as set forth in this agreement.

10. **Nonprofit status.** SUBRECIPIENT warrants that it is, and shall remain during the performance of this Agreement, a private nonprofit Organization as defined in the Regulations, including:
    a. That it is described in Section 501(c) of the Internal Revenue Code of 1954;
    b. That it is exempt from taxation under Subtitle A of the Internal Revenue Code of 1954;
    c. That it has an accounting system and a voluntary board; and
    d. That it practices nondiscrimination in the provision of its services.

11. **Administrative Requirements**. SUBRECIPIENT agrees to its status as a SUBRECIPIENT, and accepts among its duties and responsibilities the following:

    a) **Financial Management.** SUBRECIPIENT shall comply with Generally Accepted Accounting Principles (GAAP) or another equally accepted basis of accounting, use adequate internal controls, and maintain necessary sources documentation for all costs incurred.

    b) **Revenue Accounting.** Grant revenue and expenses generated under this Agreement should be recorded in compliance with generally accepted accounting principles and/or governmental accounting standards. This requires that the revenues are treated as unearned income or "deferred" until the compliance requirements and objectives of the grant have been met. Revenue may be recognized throughout the life cycle of the grant as the funds are "earned". All grant revenues not fully earned and expended in compliance with the requirements and objectives at the end of the period of performance must be returned to the County within 15 days.

    c) **Budget.** SUBRECIPIENT use of funds may not exceed the amounts specified in the Exhibit B: SUBRECIPIENT Program Budget. SUBRECIPIENT agrees to expend funds in accordance with the approved budget provided in this agreement. All expenditures that exceed a budget line item by more than 10% or $500, whichever is greater, must be approved in writing by COUNTY. Budget revisions must be submitted and approved prior to changing the budget. At no time may budget modifications change the scope of the original grant application or agreement.

    d) **Allowable Uses of Funds**. SUBRECIPIENT shall use funds only for those purposes authorized in this Agreement and in accordance with Clackamas County and Oregon Early Learning Division.

    e) **Period of Availability.** SUBRECIPIENT may charge to the award only allowable costs resulting from obligations incurred during the term and effective date. Cost incurred prior or after this date will be disallowed.

    f) Match. Matching funds are not required for this Agreement**.**

    g) **Payment.** Routine requests for reimbursement should be submitted monthly by the 15th of the following month using the form and instructions in Exhibit D: Request for

Reimbursement. SUBRECIPIENT must submit a final request for payment no later than fifteen (15) days after the end date of this Agreement.

h) **Performance and Financial Reporting.** SUBRECIPIENT must submit Performance Reports according to the schedule specified in Exhibit C: SUBRECIPIENT Performance Reporting. SUBRECIPIENT must submit Financial Reports according to the schedule specified in Exhibit D: Request for Reimbursement. All reports must be signed and dated by an authorized official of SUBRECIPIENT.

i) **Audit**. SUBRECIPIENT shall comply with the audit requirements prescribed by State and Federal law.

j) **Monitoring.** SUBRECIPIENT agrees to allow access to conduct site visits and inspections of financial and programmatic records for the purpose of monitoring. COUNTY, and its duly authorized representatives shall have access to such records and other books, documents, papers, plans, records of shipments and payments and writings of SUBRECIPIENT that are pertinent to this Agreement, whether in paper, electronic or other form, to perform examinations and audits and make excerpts, copies and transcripts. Monitoring may be performed onsite or offsite, at COUNTY's discretion.

k) **Record Retention**. SUBRECIPIENT will retain and keep accessible all such financial records, books, documents, papers, plans, records of shipments and payments and writings for a minimum of six (6) years following the Project End Date (June 30, 2021), or such longer period as may be required by applicable law, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever date is later.

l) **Failure to Comply.** SUBRECIPIENT acknowledges and agrees that this agreement and the terms and conditions therein are essential terms in allowing the relationship between COUNTY and SUBRECIPIENT to continue, and that failure to comply with such terms and conditions represents a material breach of the original contract and this agreement. Such material breach shall give rise to COUNTY's right, but not obligation, to withhold SUBRECIPIENT grant funds until compliance is met, reclaim grant funds in the case of omissions or misrepresentations in financial or programmatic reporting, or to terminate this relationship including the original contract and all associated amendments.

12. **Compliance with Applicable Laws**

a) **Public Policy**. SUBRECIPIENT expressly agrees to comply with all public policy requirements, laws, regulations, and executive orders issued by the Federal government, to the extent they are applicable to the Agreement: (i) Titles VI and VII of the Civil Rights Act of 1964, as amended; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Americans with Disabilities Act of 1990, as amended; (iv) Executive Order 11246, as amended; (v) the Health Insurance Portability and Accountability Act of 1996; (vi) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (vii) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (viii) all regulations and administrative rules established pursuant to the foregoing laws; and (ix) all other applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations; and as applicable to SUBRECIPIENT.

b) **State Statutes**. SUBRECIPIENT expressly agrees to comply with all statutory requirements, laws, rules, and regulations issued by the State of Oregon, to the extent they are applicable to the agreement.

c) **Conflict Resolution.** If conflicts are discovered among federal, state and local statutes, regulations, administrative rules, executive orders, ordinances and other laws applicable to the Services under the Agreement, SUBRECIPIENT shall in writing request COUNTY resolve the

conflict. SUBRECIPIENT shall specify if the conflict(s) create a problem for the design or other Services required under the Agreement.

General Agreement Provision

a) **Non-appropriation Clause.** If payment for activities and programs under this Agreement extends into COUNTY's next fiscal year, COUNTY's obligation to pay for such work is subject to approval of future appropriations to fund the Agreement by the Board of County Commissioners.

b) **Indemnification.** SUBRECIPIENT agrees to indemnity and hold COUNTY harmless with respect to any claim, cause, damage, action, penalty or other cost (including attorney's and expert fees) arising from or related to SUBRECIPIENT's negligent or willful acts or those of its employees, agents or those under SUBRECIPIENT's control. SUBRECIPIENT is responsible for the actions of its own agents and employees, and COUNTY assumes no liability or responsibility with respect to SUBRECIPIENT's actions, employees, agents or otherwise with respect to those under its control.

c) **Insurance**. During the term of this agreement, SUBRECIPIENT shall maintain in force, at its own expense, each insurance noted below:

1) **Commercial General Liability**. SUBRECIPIENT shall obtain, at SUBRECIPIENT's expense, and keep in effect during the term of this agreement, Commercial General Liability Insurance covering bodily injury, death, and property damage on an "occurrence" form in the amount of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate for the protection of COUNTY, its officers, commissioners, and employees. This coverage shall include Contractual Liability insurance for the indemnity provided under this agreement. This policy(s) shall be primary insurance as respects to COUNTY. Any insurance or self-insurance maintained by COUNTY shall be excess and shall not contribute to it.

2) **Commercial Automobile Liability**. If the Agreement involves the use of vehicles, SUBRECIPIENT shall obtain at SUBRECIPIENT expense, and keep in effect during the term of this agreement, Commercial Automobile Liability coverage including coverage for all owned, hired, and non-owned vehicles. The combined single limit per occurrence shall not be less than $1,000,000.

3) **Professional Liability**. If the Agreement involves the provision of professional services, SUBRECIPIENT shall obtain and furnish COUNTY evidence of Professional Liability Insurance covering any damages caused by an error, omission, or negligent act related to the services to be provided under this agreement, with limits not less than $2,000,000 per occurrence for the protection of COUNTY, its officers, commissioners and employees against liability for damages because of personal injury, bodily injury, death, or damage to property, including loss of use thereof, and damages because of negligent acts, errors and omissions in any way related to this agreement. COUNTY, at its option, may require a complete copy of the above policy.

4) **Workers' Compensation.** Insurance in compliance with ORS 656.017, which requires all employers that employ subject workers, as defined in ORS 656.027, to provide workers' compensation coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). If contractor is a subject employer, as defined in ORS 656.023, contractor shall obtain employers' liability insurance coverage limits of not less than $1,000,000.

5) **Additional Insured Provisions**. All required insurance, other than Professional Liability, Workers' Compensation, and Personal Automobile Liability and Pollution

Liability Insurance, shall include "Clackamas County, its agents, officers, and employees" as an additional insured, as well as the but only with respect to SUBRECIPIENT's activities under this agreement.

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

7) **Notice of Cancellation.** There shall be no cancellation, material change, exhaustion of aggregate limits or intent not to renew insurance coverage without 30 days written notice to the COUNTY. Any failure to comply with this provision will not affect the insurance coverage provided to COUNTY. The 30 day notice of cancellation provision shall be physically endorsed on to the policy.

8) **Insurance Carrier Rating**. Coverage provided by SUBRECIPIENT must be underwritten by an insurance company deemed acceptable by COUNTY. Insurance coverage shall be provided by companies admitted to do business in Oregon or, in the alternative, rated A- or better by Best's Insurance Rating. COUNTY reserves the right to reject all or any insurance carrier(s) with an unacceptable financial rating.

9) **Certificates of Insurance.** As evidence of the insurance coverage required by this agreement, SUBRECIPIENT shall furnish a Certificate of Insurance to COUNTY. No agreement shall be in effect until the required certificates have been received, approved, and accepted by COUNTY. A renewal certificate will be sent to COUNTY 10 days prior to coverage expiration.

10) **Primary Coverage Clarification**. SUBRECIPIENT coverage will be primary in the event of a loss and will not seek contribution from any insurance or self-insurance maintained by, or provided to, the additional insureds listed above.

11) **Cross-Liability Clause**. A cross-liability clause or separation of insured's condition will be included in all general liability, professional liability, and errors and omissions policies required by the agreement.

Waiver of Subrogation. SUBRECIPIENT agrees to waive their rights of subrogation arising from the work performed under this Agreement.

a) **Assignment.** SUBRECIPIENT shall not enter into any subcontracts or subawards for any of the Program activities required by the Agreement without prior written approval. This Agreement may not be assigned in whole or in part with the express written approval of COUNTY.

b) **Independent Status.** SUBRECIPIENT is independent of COUNTY and will be responsible for any federal, state, or local taxes and fees applicable to payments hereunder. SUBRECIPIENT is not an agent of COUNTY and undertakes this work independent from the control and direction of COUNTY excepting as set forth herein. SUBRECIPIENT shall not seek or have the power to bind COUNTY in any transaction or activity.

c) **Notices.** Any notice provided for under this Agreement shall be effective if in writing and (1) delivered personally to the addressee or deposited in the United States mail, postage paid, certified mail, return receipt requested, (2) sent by overnight or commercial air courier (such as Federal Express), (3) sent by facsimile transmission, with the original to follow by regular mail; or, (4) sent by electronic mail with confirming record of delivery confirmation through electronic mail return-receipt, or by confirmation that the electronic mail was accessed, downloaded, or printed. Notice will be deemed to have been adequately given three days following the date of mailing, or immediately if personally served. For service by facsimile or by electronic mail, service will be deemed effective at the beginning of the next working day.

d) **Governing Law.** This Agreement is made in the State of Oregon, and shall be governed by and construed in accordance with the laws of that state. Any litigation between COUNTY and SUBRECIPIENT arising under this Agreement or out of work performed under this Agreement shall occur, if in the state courts, in the Clackamas County court having jurisdiction thereof, and if in the federal courts, in the United States District Court for the State of Oregon.

e) **Severability**. If any provision of this Agreement is found to be illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the provision shall be stricken.

f) **Counterparts.** This Agreement may be executed in any number of counterparts, all of which together will constitute one and the same agreement. Facsimile copy or electronic signatures shall be valid as original signatures.

g) **Third Party Beneficiaries**. Except as expressly provided in this Agreement, there are no third party beneficiaries to this Agreement. The terms and conditions of this Agreement may only be enforced by the parties.

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

i) **Integration**. This agreement contains the entire agreement between COUNTY and SUBRECIPIENT and supersedes all prior written or oral discussions or agreements.

SUBRECIPIENT
Metropolitan Family Services
1808 SE Belmont
Portland, OR 97214

By: Judy Strand
_____
Judy Strand, MFS Chief Executive Officer

Dated: November 5, 2021

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

By: _____
Tootie Smith, Board Chair
Clackamas County

Dated: _____

- Exhibit A-1: Scope of Work
- Exhibit A-2: Work Plan Quarterly Report
- Exhibit B: Program Budget
- Exhibit C: Quarterly Demographic Report
- Exhibit D-1: Request for Reimbursement
- Exhibit D-2: Monthly Activity Report

EXHIBIT A-1
SCOPE OF WORK

Contractor shall provide Family Resource Coordination Services ("Work") as described in this Exhibit A-1 and A-2.

The Early Learning Hub of Clackamas County receives its funding from the State of Oregon's Early Learning Division whose mission it is *"to support all of Oregon's young children and families to learn and thrive. We value equity v. making a positive impact for children and .families, dedication, integrity and collective wisdom to ben /it Oregon children and families* ".

Our local Hub aligns with the State in its daily operations by working as an integrated team focused on: Child Care, Early Learning Programs and Cross Systems Integration, Policy and Research, and Equity.

A primary strategy of our Hub is to strengthen the comprehensive Family Resource Coordination system that places Family Resource Coordinators in targeted Health Equity Zones to create optimal access to quality programming. Health Equity Zones in North Clackamas County include:

1. North Clackamas Regions A & B

Program Goals

The Family Resource Coordinator (FRC) is responsible for coordinating resources and services for families with children ages 0-6 prioritizing those who experience barriers to school success, in order to meet comprehensive Kindergarten Readiness goals including cognitive, language/literacy, social/emotional, behavioral, motor skills, health and well-being. The FRC operates in a specified Health Equity Zone to receive, coordinate, and expedite service referrals for families and help them navigate healthcare, education, and other human service systems. The FRC follows-up with families and service providers to ensure timely access and assure that services have effectively met mutually identified needs.

FRC primary tasks and goals Work include:

1. Being knowledgeable about early childhood development, childhood trauma, Adverse Childhood Experiences (ACEs), transitions, kindergarten readiness, impact of social determinants of health, and other risk factors, as well as the available service/referral options to meet each family's needs.
2. Building formal agreements with other family service providers, such as medical providers, educators,home visitors, school counselors, peer mentors, OHS Case Workers, parent coaches, and others to facilitate seamless referral and access to these services for families.
3. Accepting referrals from parents, school districts, early childhood providers, health providers, human and social service providers, and other child-serving entities.
4. Meeting with referred families to establish a menu of mutually agreed upon service and referral priorities.
5. Monitoring progress and timely follow-up with families to eliminate barriers to accessing recommended services.

6. Facilitating family's access to appropriate health and early childhood systems of screening and assessment (child development, medical, dental, mental health including childhood trauma and toxic stress, kindergarten readiness, and risk factors, etc.).
7. Utilizing Early Learning Hub required database platform to enter and track all client data, contacts, referrals and outcomes, on a continual basis, as work with clients occurs.
8. Participating in multi-specialist staffing sessions for struggling families with multiple destabilizing problems and utilizing multi-specialist teams such as Teacher Assistance Teams and Youth Services Teams.
9. Document comprehensive information about community resources through networks, databases, and partnership opportunities. Utilize and teach families to use Information & Referral tools such as 211, BabyLink, Help Me Grow, and Child Care Resource & Referral. Develop a menu of frequently needed services including, but not limited to basic needs, support groups, vocational development, parents supports and education, mentors, tutors, and social/emotional counseling and support
10. Submit monthly and quarterly reports and invoices as requested via the Clackamas County required reporting database and/or paper reports as requested.

EXHIBIT A-2

Work Plan and Quarterly Report

Clackamas County Children, Family & Community Connections Division
Early Learning Hub of Clackamas County
Work Plan and Quarterly Report

Provider: Metropolitan Family Services- Region:
Program: Family Resource Coordination
Quarter:
Reporting Period: October 1, 2021-– December 31, 2022

Hub Goals:

1. Aligned, coordinated, and family-centered early childhood system
2. Children are supported to enter school ready to succeed
3. Families are healthy, stable and attached

Activities/Outputs	Intermediate Outcomes/Measurement Tool		Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022	Oct-Dec 2022			
By Dec 31, 2022, 200 Families with children (0-6) will be referred and connected to holistic services that promote family stability, healthy child development, and school readiness.	**85% of families** are referred to school staff, family advocates, home visitors, early childhood specialists, behavioral health, and employment specialists.	# Families referred								
		# Families Successfully Connected								
	85% of families will complete early childhood screening and assessments (Developmental, medical, dental, vision, hearing, etc).	# Families referred for screening/ assessments								
		# Families completing screening/ assessments								
	85% of families will be referred to a pediatrician, establish a medical/dental home, insurance enrollment support, and will be offered other health services that promote resiliency and increase protective factors.	# Families referred								
		# Families Successfully Connected								
By Dec 31, 2022, Program participants will receive a minimum of **4** contacts, one of which will be face to face. *Contact is defined as*: face to face, phone call, email, or texting.	**85% of families** will follow through with mutually agreed upon referrals: assessments, treatment options, and family requested supports.	# Families Served								
		# Successful Follow Through on Plans								
By Dec 31, 2022, 150 families will be educated to use Information and Referrals systems i.e. 211info, BabyLink, CCR&R, TriMet Ride, IMATCH, Help Me Grow, etc.	**85% of parents** report that they know how to use I&R systems	# Families Served								
		# Families that report knowing how to use I&R services								
By Dec 31, 2022, all parents served by FRC will receive information on school/ kindergarten readiness, transition to school, literacy, and social/emotional development.	**100%** of families served by FRC will receive kindergarten readiness, successful transitions, literacy, and social emotional development information.	# Families Served								
List Schools, Districts, Community Based Organizations, medical providers, etc. that participated in planning/implementation/ongoing support and referrals of FRC work:										
List community meetings attended during the reporting period:										

Children, Family and Community Connections Division
Early Learning Hub of Clackamas County
Family Resource Coordination
Work Plan 2021-2022
Comments and Narrative

Provider/ Location:
Quarter:

1. Provide detailed information to explain the numbers and activities reported in the work plan above.

    a. General project information:

    b. Professional Development Activities:

    c. Family Focused Activities:

    d. Child Focused Activities:

2. What are your **successes** this quarter, and what are some of the most impactful practices that your organization has implemented as a result of this project?

3. What **challenges** have you experienced this quarter?

    Family Success Stories:

FRC Reporting Requirements

Monthly report, general ledger and reimbursement request

- No later than the 15th of every month
- Reports go to: Dani Stamm Thomas dstammthomas@clackamas.us
- All reports need to CC: Chelsea Hamilton Chamilton@clackamas.us and Stephanie Radford SRadford@clackamas.us

Quarterly Report, Client Satisfaction Surveys and Demographic Data Forms due:

- Oct-Dec **Due January 15, 2022**
- Jan-Mar **Due April 16, 2022**
- April-June **Due July 16, 2022**
- July-Sept **Due October 15, 2022**
- Oct-Dec **Due January 15, 2023**

Client Satisfaction Surveys

Clackamas County's initiative to measure client satisfaction with direct services provided or funded by the county (if applicable).

Exhibit B: Budget

Exhibit B: Budget					
Contractor:	Metropolitan Family Services		**FRC**		
Program:	Family Resource Coordinator				
Address:					
Contact Person:	Meghan Zook		**Contract #:**		
Phone Number:			**Contract Term:**		10/1/21-12/31/22
E-mail:	meganz@mfs.email				

Budget Category	Approved Budget 10/1/21-12/31/22		Total Budget
Personnel			
Family Resource Coordinator Region A .77fte	$ 46,780.24	$ -	$ 46,780.24
Family Resource Coordinator Region B .77fte	$ 47,028.80	$ -	$ 47,028.80
Supervision .0625fte	$ 4,649.13	$ -	$ 4,649.13
Fringe	$ 28,601.83	$ -	$ 28,601.83
			$ -
	$ 127,060.00	**$ -**	**$ 127,060.00**
Administration			
Admin 15%	$ 19,059.00	$ -	$ 19,059.00
	$ 19,059.00	**$ -**	**$ 19,059.00**
Program costs			
Materials/Supplies	$ -	$ -	$ -
Mileage	$ -	$ -	$ -
Additional (please specify)			
	$ -	$ -	$ -
	$ -	**$ -**	**$ -**
Total Budget	**$ 146,119.00**	**$ -**	**$ 146,119.00**

EXHIBIT C: Quarterly Demographics Report

Quarterly Demographics Report														
Program: FRC Region A	**Provider: Metropolitan Family Service**													
Race/Ethnicity	**Program Participants Served**													
• *Participants should be counted in one category of race/ethnicity.* • *Participants that identify as multi-racial should be counted in that category and the particular racial mix should be included in a narrative.*	First quarter count ALL clients as new													**TOTAL SERVED YTD**
	Oct-Dec 21	Jan-Mar 22			Apr-Jun 22			July-Sep 22			Oct-Dec 22			
		NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	
American Indian and Alaska Native														
American Indian														0
Alaska Native														0
Canadian Inuit, Metis or First Nation *(please identify in narrative)*														0
Asian														0
Chinese														0
Vietnamese														0
Korean														0
Laotian														0
Filipino														0
Japanese														0
South Asian														0
Asian Indian														0
Other Asian *(please identify in narrative)*														0
Black/African American														
African American														0
African														0
Caribbean														0
Other Black *(please identify in narrative)*														0
Hispanic or Latino														
Hispanic or Latino Mexican														0
Hispanic or Latino Central American														0
Hispanic or Latino South American														0
Other Hispanic or Latino *(please identify in narrative)*														0
Indigenous Mexican, Central American or South American *(please identify)*														0
Pacific Islander														
Native Hawaiian														0
Guamanian or Chamorro														0
Samoan														0
Other Pacific Islander *(please identify in narrative)*														0
White														0
Slavic														0
Middle Eastern														0
North African														0
Multi-Racial *(please identify in narrative)*														0
Decline to Answer														0
Unknown														0
TOTAL BY RACE/ETHNICITY	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Primary Language														
Cantonese														0
English														0
Russian														0
Spanish														0
Ukranian														0
Vietnamese														0
Other *(list language in narrative)*														0
TOTAL BY LANGUAGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gender Identification														
Female														0
Male														0
Transgender														0
Unknown or Declined to Say														0
TOTAL BY GENDER	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Age														
0-6														0
7-12														0
13-17														0
18-24														0
25-59														0
60+														0
Unknown or Declined														0
TOTAL BY AGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Race/Ethnicity ***TOTAL*** *, Gender* ***TOTAL*** *and Age* ***TOTALs*** *should match.*														

Quarterly Demographics Report														
Program: FRC Region B	**Provider: Metropolitan Family Service**													
Race/Ethnicity	**Program Participants Served**													
• *Participants should be counted in one category of race/ethnicity.* • *Participants that identify as multi-racial should be counted in that category and the particular racial mix should be included in a narrative.*	First quarter count ALL clients as new													**TOTAL SERVED YTD**
	Oct-Dec 21	Jan-Mar 22			Apr-Jun 22			July-Sep 22			Oct-Dec 22			
		NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	
American Indian and Alaska Native														
American Indian														0
Alaska Native														0
Canadian Inuit, Metis or First Nation *(please identify in narrative)*														0
Asian														0
Chinese														0
Vietnamese														0
Korean														0
Laotian														0
Flipino														0
Japanese														0
South Asian														0
Asian Indian														0
Other Asian *(please identify in narrative)*														0
Black/African American														
African American														0
African														0
Caribbean														0
Other Black *(please identify in narrative)*														0
Hispanic or Latino														
Hispanic or Latino Mexican														0
Hispanic or Latino Central American														0
Hispanic or Latino South American														0
Other Hispanic or Latino *(please identify in narrative)*														0
Indigenous Mexican, Central American or South American *(please identify)*														0
Pacific Islander														
Native Hawaiian														0
Guamanian or Chamorro														0
Samoan														0
Other Pacific Islander *(please identify in narrative)*														0
White														0
Slavic														0
Middle Eastern														0
North African														0
Multi-Racial *(please identify in narrative)*														0
Decline to Answer														0
Unknown														0
TOTAL BY RACE/ETHNICITY	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Primary Language														
Cantonese														0
English														0
Russian														0
Spanish														0
Ukranian														0
Vietnamese														0
Other *(list language in narrative)*														0
TOTAL BY LANGUAGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gender Identification														
Female														0
Male														0
Transgender														0
Unknown or Declined to Say														0
TOTAL BY GENDER	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Age														
0-6														0
7-12														0
13-17														0
18-24														0
25-59														0
60+														0
Unknown or Declined														0
TOTAL BY AGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Race/Ethnicity ***TOTAL*** *, Gender* ***TOTAL*** *and Age* ***TOTALs*** *should match.*														

EXHIBIT D-1: REIMBURSEMENT REQUEST

Exhibit D-1: REQUEST FOR REIMBURSEMENT

Requests for reimbursement and supporting documentation are due monthly by the 15th of the month, including:
- **Request for Reimbursement with an authorized signature**
- **General Ledger backup to support the requested amount**
- **Monthly Activity Report (Exhibit D-2) showing numbers served and activities conducted during the month of request** ***(The Monthly Activity Report is NOT required on months when quarterly reports are due).***

Contractor:	Metropolitan Family Services	**Contract Number:**	
Address:		**Report Period:**	
Contact Person:	Meghan Zook		
Contact Info:	meganz@mfs.email		**FRC**
Term:	10/1/21-12/31/22		

Budget Category	Approved Budget (10/1/21-12/31/22)	Current Draw Request	Previously Requested	Balance
Personnel				
Family Resource Coordinator Region A .77fte	$ 46,780.24	$ -	$ -	$ 46,780.24
Family Resource Coordinator Region B .77fte	$ 47,028.80	$ -	$ -	$ 47,028.80
Supervision .0625fte	$ 4,649.13	$ -	$ -	$ 4,649.13
Fringe	$ 28,601.83	$ -	$ -	$ 28,601.83
	$ 127,060.00	**$ -**	**$ -**	**$ 127,060.00**
Administration				
Admin 15%	$ 19,059.00	$ -	$ -	$ 19,059.00
	$ 19,059.00	**$ -**	**$ -**	**$ 19,059.00**
Program costs				
Materials/Supplies	$ -	$ -	$ -	$ -
Mileage	$ -	$ -	$ -	$ -
Additional (please specify)				
	$ -	$ -	$ -	$ -
	$ -	**$ -**	**$ -**	**$ -**
Total Budget	**$ 146,119.00**	**$ -**	**$ -**	**$ 146,119.00**

Clackamas County retains the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of Recipient that are pertinent to this Agreement.

CERTIFICATION

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and represents actual expenditures, disbursements and cash receipts for the purposes and objectives set forth in the terms of the agreement.

EXHIBIT D-2: MONTHLY ACTIVITY REPORT

Agency: Metropolitan Family Services

Funded Service: Family Resource Coordinator

Program Contact:

Month:

This report covers the fiscal year starting ***October 1, 2021 through December 31, 2022.*** *Complete the sections below as they apply to the group(s) targeted for services with this funding as outlined in your Work Plan.*

Submit this report with monthly requests for reimbursement except on months when the quarterly report is submitted.

1. **Total number of participants served during the month with the funding allocated for this programming:**

   Number of children:

   Number of Families:

2. **Activities that were conducted during the month with the funding allocated for this programming:**

3. **Issues related to service delivery and how those issues were addressed.**

Person(s) completing this form:
Date:

CLACKAMAS COUNTY

PLANNING & ZONING DIVISION

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT

DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of an Urban Growth Management Agreement (UGMA)
between the City of Happy Valley and Clackamas County-
Happy Valley UGMA East

Purpose/Outcome	Consideration of a new Urban Growth Management Agreement (UGMA) between the County and the City of Happy Valley for areas located south and east of the city; this agreement outlines planning responsibilities for areas in portions of the former city of Damascus that the City is interested in potentially annexing and urbanizing in the future.
Dollar Amount and Fiscal Impact	None
Funding Source	None
Duration	The UGMA will become effective upon execution of the agreement and continue for ten (10) years and will automatically renew for an additional ten (10) years if not terminated by either party.
Previous Board Action/Review	*May 11, 2021, Policy Session*: BCC reviewed UGMA draft and directed staff to finalize this document with city and proceed to adoption.
Strategic Plan Alignment	*1. How does this item align with your Department's Strategic Business Plan goals?* This item aligns with the Long-Range Planning program's purpose of providing land use and transportation plan development, analysis, coordination and public engagement services to residents; businesses; local, regional and state partners; and County decision-makers so they can plan and invest based on a coordinated set of goals and policies that guide future development. *2. How does this item align with the County's Performance Clackamas goals?* The item aligns with the Performance Clackamas goal to "Build Public Trust through Good Government". Creating coordination

Counsel Review	11/4/21 N Boderman
Procurement Review	1. Was the item processed through Procurement? yes ☐ no X 2. If no, provide brief explanation: This item is an IGA between the county and the city.
Contact Person	Martha Fritzie, Principal Planner – Planning and Zoning Division, (503) 742-4529 (mfritzie@clackamas.us)
Contract No.	Not applicable

BACKGROUND:

As required by state statute, Clackamas County has an urban growth management agreement (UGMA) with every city in the county except Portland (because city of Portland lands within the county are so minimal). These UGMAs are necessary for management of areas of mutual interest to coordinate planning and service delivery so as to provide a smooth transition when lands are annexed and to provide certainty for property owners via consistent policies and standards for development. Each agreement is individually negotiated and pertains to specific issues between the County and that City.

It is important to understand that an UGMA agreement does not lead to immediate annexation of properties. It is simply a "political contract" for the jurisdictions to have in place for consideration of future annexation and provision of all urban services by specific providers in a targeted geographic area. This geographic area is considered the "area of interest" for the City.

The UGMA proposed for adoption today ("Happy Valley UGMA East") has been developed cooperatively over the past several years to address land use coordination and annexation issues, and, most importantly, to clarify roles for urban planning and urban service provision for a portion of the former city of Damascus. Planning, engineering and legal staff from both the city and the county have reviewed and provided extensive comments, suggestions, and edits to the various drafts of the Happy Valley UGMA East.

The Happy Valley UGMA East will be a separate agreement from the existing UGMA with the city of Happy Valley and will apply to a different geographic area than the existing UGMA, which generally covers the urban areas west of the city to I-205 and south of the city to the urban growth boundary. No changes are being proposed to this existing UGMA, except that it would now be referred to as the "Happy Valley UGMA West".

The Happy Valley UGMA East:

- Specifies that county Comprehensive Plan and zoning regulations continue to apply within the UGMA area until land is annexed into city and the county will continue to process all land use applications and permitting activities in such areas;
- Identifies the city as the jurisdiction that will ultimately be responsible for urbanizing lands within the UGMA area that are currently still in rural zoning districts, including:
    - Developing and adopting urban plans for such lands within the UGMA area, including urban public facilities plans;

    - Coordinating with county staff and inviting county staff to participate in relevant advisory committees relevant to the development of urban plans for the area; and
    - Working together with county staff to identify opportunities for land to provide employment uses, as well as lands for the development of affordable housing;
- Identifies certain conditions that need to be met for roadway segments to be transferred from the county to the city upon annexation of abutting properties.
- Identifies notification responsibilities for both the county and city as they relate to land use applications and other permitting activities; and
- Includes other general legal, term length and termination language, all of which has been drafted and reviewed by legal staff.

In May, 2021, the Board discussed the Happy Valley UGMA at a Policy Session and directed staff to finalize the document with city and proceed to adoption at a Business Meeting.

The Happy Valley UGMA East (attached) has been reviewed and approved by County Counsel and was approved and signed by the City of Happy Valley in October 2021.

RECOMMENDATION:

The Planning and Zoning Division respectfully recommends the Board approve the UGMA as submitted.

Respectfully submitted,

Jennifer Hughes

Jennifer Hughes, Planning Director
Planning and Zoning Division

CITY OF HAPPY VALLEY/CLACKAMAS COUNTY

URBAN GROWTH MANAGEMENT AGREEMENT

This Urban Growth Management Agreement ("UGMA" or "Agreement"), by and between the City of Happy Valley, an Oregon municipal corporation ("City") and Clackamas County, a political subdivision of the State of Oregon ("County") (collectively, the "Parties," and each individually a "Party").

RECITALS

WHEREAS, authority is conferred upon local government under ORS 190.010 to enter into an agreement for the performance of functions and activities that the local government, its officers or agencies has authority to perform; and

WHEREAS, the City and the County have a common interest in coordinated comprehensive plans, compatible land uses and coordinated planning of urban facilities within the Happy Valley Urban Planning Area East ("HVUPAE"), as described in Exhibit A to this Agreement; and

WHEREAS, the exchange of information should concentrate on issues that may have a significant impact on either Party and should not entail cumbersome procedural requirements that may increase the time necessary to expedite decision making; and

WHEREAS, OAR 660-003-0010 requires management plans for unincorporated areas within an urban growth boundary to be set forth in a statement submitted to the Land Conservation and Development Commission ("LCDC") at the time of acknowledgement request; and

WHEREAS, OAR 660-011-0015 requires an urban growth management agreement to specify the entity responsible for the preparation, adoption and amendment of the public facility plan(s); and

WHEREAS, the City and County previously entered into an urban growth management agreement on January 30, 1992, and amended on June 19, 2001, and subsequently amended on November 18, 2013 for areas to the west and southwest of the existing City of Happy Valley (extending to the Veterans Memorial Highway), which is hereby referred to as the "UGMA WEST" and is a separate urban growth management agreement from this Agreement, which is hereby referred to as the "UGMA EAST".

NOW THEREFORE, the Parties agree as follows:

AGREEMENT

1. Definitions.

As used in this Agreement, the following words shall mean or include:

1.1 Comprehensive Plan. Any plan document as described in ORS 197.015(5) that is adopted by a Party and that applies within the HVUPAE.

1.1.1 City Comprehensive Plan. The City of Happy Valley Comprehensive Plan.

1.1.2 County Comprehensive Plan. The Clackamas County Comprehensive Plan.

1.2 Land Use Policies. The whole or any part of any comprehensive plan, subarea comprehensive plan, Title 16 of the City's Municipal Code ("Development Code"), the Clackamas County Zoning and Development Ordinance ("ZDO"), refinement plan, public facility plan developed under OAR Chapter 660, Division I, land use regulation as defined by ORS 197.015(11), or any other generally applicable policy regulating the use or development of land. As applied to Metro, "Land Use Policies" include Planning Goals and Objectives, Regional Urban Growth Goals and Objectives, Functional Plans, and Regional Framework Plans.

1.3 Happy Valley Urban Planning Area East ("HVUPAE"). The HVUPAE includes unincorporated land within the Portland Metropolitan Urban Growth Boundary ("UGB") located generally east of 172nd Avenue and west of 222nd Avenue, as illustrated on the map attached as Exhibit A to this Agreement.

2. Terms of this Agreement.

2.1 This UGMA EAST becomes effective as specified under Section 8.3, below, and shall continue thereafter for an initial term of 10 years, unless terminated as provided in this Section or modified consistent with Section 8.4. This Agreement automatically renews for one additional 10-year term unless, not later than 90 days prior to the expiration of the initial term of this UGMA, one of the Parties provides the other Party with written notice that it does not wish to renew the UGMA EAST, in which case this UGMA will automatically terminate upon completion of the initial 10-year term. Either Party may terminate this agreement at any time after providing at least 90 days written notice to the other Party.

3. General Provisions.

3.1 General Planning and Permitting Responsibilities

3.1.1 Comprehensive Plan/Zoning Designations and Amendments. The County Comprehensive Plan and zoning shall apply to all unincorporated land within the HVUPAE until such time as those lands are annexed into the City. Unless

otherwise provided by law, the development of a comprehensive plan map amendment or zone change for the unincorporated areas within the HVUPAE shall be a coordinated joint effort of the Parties. The County shall be responsible for preparing and making a decision on all legislative and quasi-judicial comprehensive plan amendments/zone changes for areas within the HVUPAE not annexed to the City in coordination with the City and consistent with state law and the Metro Functional Plan. The City shall have the unrestricted right to review, comment on and appeal all legislative and quasi-judicial comprehensive plan amendments/zone changes processed by the County within the HVUPAE.

3.1.2

Land Use Permitting Authority. The County Comprehensive Plan and land use regulations shall apply to an application for a permit or other land use review within the HVUPAE not annexed to the City. County shall retain responsibility and authority for all implementing regulations and land use actions for all unincorporated lands within the HVUPAE, until lands are annexed to the City.

For properties that annex into the City of Happy Valley in the HVUPAE, the City shall apply the underlying County Plan and zone provisions in accordance with the procedural framework of the City's Municipal Code until the City has adopted urban City Comprehensive Plan designations and zoning districts for the HVUPAE.

3.1.3

Urban Plan Development. The Parties agree that the City shall be responsible for developing and adopting an urban Comprehensive Plan and zoning districts for areas that do not currently have urban designations within the HVUPAE, per Section 4 of this Agreement.

3.1.4 Land Divisions. Land divisions that would create parcels smaller than 20 acres in size shall not occur within lands with a Rural Comprehensive Plan designation within the HVUPAE.

3.2 Annexation.

3.2.1 Conditions Requiring Annexation. The owner(s) of property adjacent to the City (including by extension of a public right-of-way or body of water, per the City's annexation policies), who are seeking access to City-provided services (for example, Planning, Engineering, or Building Division permits) may be required to submit an annexation petition to the City.

3.2.2 Annexation Consent. At the discretion of the Board of County Commissioners ("Board"), the County may provide consent for annexations, when such consent is required per ORS 222.170 or ORS 222.125 for properties utilizing county right-of-way for an annexation, if city agrees to accept the transfer of the section of the roadway being used to access the annexed property.

3.2.3 Annexation Plan. Any City-initiated Annexation Plan shall be developed consistent with applicable state and regional laws. Opportunity shall be provided

to citizens, the County, active Citizen Planning Organizations ("CPOs") and affected service providers to review and comment on the Annexation Plan prior to any annexation election. Annexation Plan(s) will include development of public facilities plan(s) for the Annexation Plan area(s).

3.3 Public Facilities.

3.3.1 Public Facilities Plans. Except as identified in Section 4, the City shall coordinate the preparation or amendment of public facilities plans within the HVUPAE as may be required by OAR Chapter 660, Division 11 (Public Facilities Planning) and applicable sections of ORS Chapter 195 with the appropriate service providers. Upon annexation, an area within the HVUPAE shall be provided with public facilities services through a combination of City-provided services and by way of Intergovernmental Agreements ("IGAs") with applicable service providers, which may include the following: sanitary storm services – Water Environment Services "WES"); water service providers – Sunrise Water Authority, Clackamas River Water; county road services – Clackamas County Department of Transportation and Development; fire prevention services – Clackamas Fire District No. 1; services related to the provision and maintenance of open space – Metro; mass transit services – Tri-Met; and, school facility planning – North Clackamas School District No. 12, Gresham-Barlow School District, and Centennial School District.

3.3.2 New Service Districts. County shall not form any new county service districts to serve any areas within the HVUPAE, nor shall it support the annexation of any land within the HVUPAE to any such districts or to any other service districts without the prior written consent of the City.

4. Planning for Urbanization of Rural Lands in the HVUPAE.

4.1 Planning authority. The City shall be responsible for planning for any future urbanization of rural lands within the HVUPAE. The urbanization of rural lands within the HVUPAE will only occur upon annexation to the City. The City shall coordinate with the County Planning Division and other relevant County Department of Transportation and Development ("DTD") staff regarding future urban planning and development activities and the transportation network in the HVUPAE. County staff shall be invited to participate in the proceedings of all relevant Technical Advisory Committees in the review of urban plans within the HVUPAE. The City shall notify and coordinate with the County on amendments to the City's Transportation System Plan ("City TSP").

4.2 Land use and transportation planning in the HVUPAE. Building off existing studies and previously completed planning work, the City of Happy Valley and the County will develop the following planning documents for the HVUPAE:

4.2.1 Integrated Land Use and Transportation Plans (Urban Plans):
The City may create detailed, integrated land use and transportation plans for "phases," or portions of the HVUPAE that the City determines are of sufficient size to phase development and urban service provision in a cost-effective and efficient manner. These plans shall include all elements required for a full urban

comprehensive plan for the selected area.

4.2.1.1 Coordination: All integrated land use and transportation plans shall be coordinated with the County to ensure consistency with County transportation plans and other planning in adjacent unincorporated rural areas. The City shall lead this planning undertaking with County coordination and participation in all relevant committees.

4.2.1.2 Notification: The City shall notify the County Planning Director prior to the initiation of each phase of urban land use and transportation planning. Notification shall, at a minimum, include a map of the area to be planned and an estimated timeframe for adoption of an urban plan.

4.2.1.3 Providing Employment Land: The City and County recognize the importance or providing employment land to support stronger economic growth in the County and will work together to identify opportunities to provide such lands in the HVUPAE, to potentially include employment areas different than those identified as Metro Title 4 lands.

4.2.1.4 Providing Affordable Housing Opportunities: The City and County recognize the importance or providing land for the development of affordable housing in the County and will work together to identify opportunities to provide such lands in the HVUPAE.

4.2.2 Clackamas County Transportation System Plan ("County TSP"): An update of the County TSP will be developed for the Metro UGB area illustrated within Exhibit A beyond (east of) any areas inside the HVUPAE that are not part of an integrated land use and transportation plan that is adopted or actively being completed by the City. The County TSP update will plan for transportation improvements necessary to serve travel patterns that are expected in the future in and adjacent to the HVUPAE including, without limitation, those areas within the Metro UGB but outside the HVUPAE.

4.3 State Highway System Improvements. The City and County recognize the importance of working with the Oregon Department of Transportation ("ODOT") to ensure that state transportation facilities be built/improved to accommodate expected population and employment growth in the HVUPAE and will utilize any subsequent land use and transportation plans to advocate for the timely development of the Sunrise Highway.

5. Other City Responsibilities.

5.1 Functions. All functions relating to the subject matter of this Agreement not specifically listed in this Section or any Exhibit as being the responsibility of the City will remain the responsibility of County. City shall be responsible for the timely and effective distribution to County of studies, information, requests, data and personal communications in City's possession on any matter concerning coordination between the City and County and/or regarding any infrastructure or policy issues coordinated by County.

5.2 Road Jurisdiction, Transfer and Condition. The City shall assume jurisdiction of the full width of any applicable segment of County road classified by the County as minor arterial, collector, connector, or local street that is within or immediately abutting an area annexed to the City within one year of the date of that annexation, assuming all provisions detailed below have been met. The transfer and assumption of jurisdiction shall be consistent with the provisions of ORS 373.270.

Concurrent with the date that a road is transferred, the County will upgrade the roadway or provide funds equivalent to the cost of a two-inch overlay over the existing pavement area, unless the road has a Pavement Condition Index (PCI) rating of 70 or higher, or the Parties mutually agree that overlay funds are not necessary for transfer. Alternatively, if a roadway or roadway section has a PCI of 50 or less, the City will only accept said roadway once a PCI of 70 or higher is achieved by the County or the Parties mutually agree upon a funding level equivalent to upgrading of the roadway to a PCI of 70 or higher.

5.2.1 For any County minor arterial, collector, connector or local street within the City boundary that is being transferred, but subsequent to annexation, the County shall allow improvements to be constructed to City standards and defer permitting authority to the City. The City shall issue all appropriate permits directly to the developer.

5.2.2 For any improvements to a County major arterial road within the City boundary, the County shall determine if City standards along the major arterial are acceptable to the County and do the following:

A. If the City standards are acceptable to the County, the County shall allow all improvements to be constructed to City standards. The County shall issue all appropriate permits with City concurrence.
B. If the proposed cross section standards are not acceptable to the County, the County shall require those improvements to be constructed to County standards. The County shall issue all appropriate permits.

5.3. City Notice to and Coordination with the County and CPOs.

5.3.1. The City shall provide notice to the County and the appropriate active CPOs at least 20 days prior to the first public hearing on all proposed annexations or extraterritorial service extensions into unincorporated areas.

5.3.2. The City shall provide notice to the County at least 20 days prior to the first scheduled public hearing on all proposed legislative changes to the City Comprehensive Plan or any quasi-judicial hearings regarding properties adjacent to unincorporated areas within the HVUPAE.

5.3.3. The City shall notify and coordinate with the County on amendments to the City TSP.

5.3.4. City shall provide notice and a service-provider comment letter to the applicable County Department in conjunction with the City's review of any land use application or building permit in which the proposed development activity might affect County facilities.

6. Other County Responsibilities.

6.1. County Notice to and Coordination with the City for Lands in HVUPAE.

6.1.1. The County shall provide notice to the City at least 20 days prior to the first scheduled public hearing on all proposed legislative changes to the County Comprehensive Plan text, implementing ordinances or other land use policies affecting land within the HVUPAE, and shall provide notice to the City at least 20 days prior to the first scheduled quasi-judicial public hearing regarding any properties adjacent to the City's incorporated area.

6.1.2. The County shall provide notice to the City at least 20 days prior to a staff decision on any Type II application for administrative action as provided in the ZDO for property within the HVUPAE.

6.1.3. The County shall notify and invite City staff to participate in or comment on all pre-application meetings for design review, conditional use permits, partitions, subdivisions or other significant development proposals within unincorporated areas of the HVUPAE at least 15 days prior to any such meeting.

6.1.4. Any amendments proposed by the County to the UGB within one mile of the HVUPAE will be reviewed jointly by the City and the County prior to submission to Metro.

6.1.5. In any County land use proceeding affecting property within the HVUPAE, the County shall enter all written comments received from the City into the public record and shall consider such written comments in the exercise of its planning and plan implementation responsibilities.

7. Mutual Indemnification

7.1 Subject to Article XI of the Oregon Constitution and ORS 30.260 to 30.300, the City will hold harmless, defend and indemnify the County, its elected officials, officers, and employees, for and against any claims or damages to property or injury to persons, resulting in whole or part from City's acts or omissions in performing any obligations under this Agreement.

7.2 Subject to Article XI of the Oregon Constitution and ORS 30.260 to 30.300, the County will hold harmless, defend and indemnify the City, its elected officials officers and employees for and against any claims or damages to property or injury to persons, resulting in whole or part from the County's acts or omissions in performing any obligation under this Agreement.

8. General Provisions.

8.1 Applicable Law. This Agreement shall be governed by Oregon law, without giving effect to the conflict of law provisions thereof, and the Parties agree to submit to the jurisdiction of the courts of the State of Oregon.

8.2 Insurance Coverage.

8.2.1. Commercial General Liability Insurance. Each of the Parties shall obtain and maintain at all times during the course of this Agreement commercial general liability insurance coverage pursuant to Oregon Tort Claims Act and subject to the limits of the Act covering Bodily Injury and Property Damage on an "occurrence" form in the amount of not less than $1 Million per occurrence/$2 Million general aggregate for the protection of the other Party, its officers, elected officials and employees. This coverage shall include Contractual Liability insurance for the indemnity provided under this Agreement.

8.2.2. Notice of Cancellation. There shall be no cancellation, material change, exhaustion of aggregate limits or intent not to renew any Party's insurance coverage contemplated by this Agreement without 60 days written notice to the other Party. Any failure to comply with the provision will not affect the insurance coverage provided to the Party. The 60-day notice of cancellation provision shall be physically endorsed on to the policy.

8.2.3. The County may self-insure to meet the minimum insurance requirements of this Section 8.2, to the extent that it maintains a self-insurance program that complies with the insurance requirements applicable under this Section 8.2.

8.3 Effective Date and Term. This Agreement shall become effective on the last date signed below and shall continue in effect according to its Terms.

8.4 Amendment. This Agreement may be amended at any time consistent with Section 8.9 below.

8.5 Assignment. Except as otherwise provided herein, the Parties may not assign any of their rights or responsibilities under this Agreement without prior written consent from the other Party, except that a Party may delegate or subcontract for performance of any of their responsibilities under this Agreement.

8.6 Dispute Resolution.

8.6.1. Subject to mutually agreed upon extensions of time in writing, failure or unreasonable delay by any party to substantially perform any material provision of this agreement shall constitute default. In the event of an alleged default or breach of any term or condition of this agreement, the Party alleging such default or breach shall give the other Party not less than 30 days written notice specifying the nature of the alleged default and the manner in which the default may be cured satisfactorily. During this 30-day period, the Party shall not be considered in default for purposes of termination or instituting legal proceedings.

8.6.2. The Parties shall first attempt to resolve the dispute by negotiation, followed by mediation, if negotiation fails to resolve the dispute.

8.6.3. Step One: (Negotiation). Each Party will select one or more person(s) to negotiate on behalf of the entity they represent. Those person(s) shall then meet and attempt to resolve the issue. If the dispute is resolved, there shall be a written determination of such resolution, signed by a representative of each Party and ratified by the governing bodies that shall then be binding.

8.6.4. Step Two: (Mediation). If the dispute cannot be resolved within thirty (30) days at Step One, the Parties may submit the matter to mediation. The Parties shall attempt to agree on a mediator. If they cannot agree, the Parties shall request a list of five (5) mediators from an entity or firm providing mediation services. The Parties will attempt to mutually agree on a mediator from the list provided, but if they cannot agree, each Party shall select one (1) name. The two selected shall select a third person who shall serve as the mediator. The common costs of mediation borne equally by the Parties with each bearing its own costs and fees. If the issue is resolved at this step, a written determination shall be signed by each Party and approved by the governing bodies.

8.6.5. Step Three (Legal Action). If the dispute remains unresolved following mediation, the Parties may seek remedy by appropriate proceedings filed in Clackamas County Circuit Court. In any such judicial proceeding, each Party shall be responsible for its own costs and fees.

8.7 Execution in Counterparts. This Agreement may be executed in any number of counterparts, each of which may be executed by any one or more of the parties hereto, and all of such counterparts shall constitute one Agreement. Counterparts of executed signature pages may be attached to any one or more counterparts of this Agreement. To facilitate execution of this Agreement, the Parties may execute by facsimile or e-mail transmission counterparts of the signature pages.

8.8 Severability. In the event a court of competent jurisdiction deems any portion or part of this Agreement to be unlawful or invalid, only that portion of part of the Agreement shall be considered unenforceable. The remainder of this Agreement shall continue to be valid.

8.9 Entire Agreement. This Agreement constitutes the entire agreement between the Parties and supersedes any prior oral or written agreements or representations relating to the HVUPAE. No waiver, consent, modification or change of terms of this Agreement shall bind the Parties unless in writing and signed by each party.

8.10 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 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.

8.11 Debt Limitation. This Agreement 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.

8.12 Waiver. 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.

8.13 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.

8.14 No Third-Party Beneficiary. Neither Party intends that this Agreement benefit, or create any right or cause of action in, or on behalf of, any person or entity other than the County or the City.

8.15 Notices. All notices or other communications required or permitted under this Agreement shall be in writing, and shall be mailed or sent by scanned document (e-mailed) or faxed with hard copy to follow by post, addressed as follows:

To City: City of Happy Valley
Economic & Community Development Department
16000 SE Misty Drive
Happy Valley, OR 97086

To County: Clackamas County Planning & Zoning Division
150 Beavercreek Rd.
Oregon City, OR 97045

IN WITNESS WHEREOF, the respective Parties have caused to be signed on their behalf and enter into this Agreement on the last date indicated below.

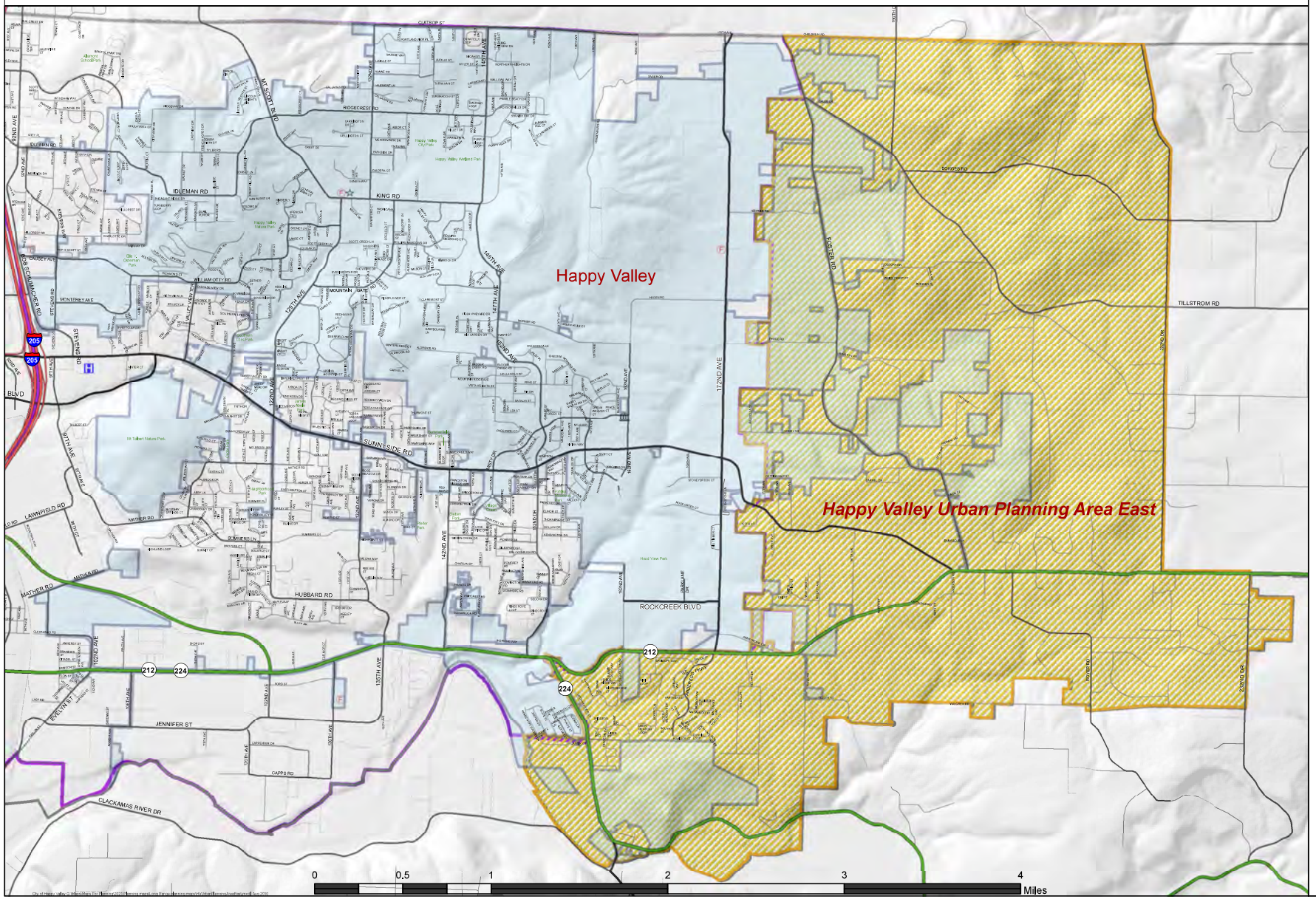
CITY OF HAPPY VALLEY

By DocuSigned by: Tom Ellis 10F50C7CEFCD433... _____ Date 10/26/2021
Mayor

CLACKAMAS COUNTY

By _____ Date _____
Chair, Board of County Commissioners

EXHIBIT A - Happy Valley Urban Planning Area East Map



CLACKAMAS COUNTY

Department of Assessment and Taxation

TAMI LITTLE
COUNTY ASSESSOR

November 23, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of 2021 House Bill 5006 Resolution

Purpose/Outcomes	Board approval of the 2021 HB 5006 Resolution
Dollar Amount and Fiscal Impact	Provides for funds of $116,831 to be distributed to all Clackamas County property tax districts.
Funding Source	A one-time General Fund appropriation by the Oregon legislature was approved for the Department of Revenue to make grants to impacted counties.
Duration	Distribution of grant funds by December 31, 2021.
Previous Board Action/Review	On November 2, 2021, the Board voted to adopt a county Resolution allowing receipt of HB 5006 grant funds and distribution per the County Tax Collector's recommendation.
Strategic Plan Alignment	Build public trust through good government
Counsel Review	11/9/2021
Procurement Review	1. Was the item processed through Procurement? yes □ no X 2. If no, provide brief explanation: This is a grant allowed by legislation with approval by the County Commissioners. No procurement involvement is required.
Contact Person	Bronson Rueda, 503-655-8304

BACKGROUND:
During the 2021 legislative session, HB 5006 was passed allowing a one-time General Fund appropriation of $23.2 million for the Department of Revenue (DOR) to make grants to counties for the reimbursement of lost tax revenue related to the 2020 wildfires. Distribution of these funds will be limited to counties included in Executive Order 20-60 that were impacted by the 2020 wildfires and that can

demonstrate losses due to the September 2020 wildfires in property tax years beginning on or after July 1, 2020.

On October 11, 2021, the Department of Revenue issued HB 5006 guidance to the impacted counties. The guidance outlines steps for counties to take, in order to receive the grant money. The steps include drafting a resolution with the amount requested, instructions on how to calculate each counties grant amount, a requirement for each county to describe how the grant money will be distributed, and a commitment for each county to provide a follow up report. The DOR will disburse the approved grant amount for tax year 2020-21 by December 31, 2021.

On November 5, 2021, the Department of Revenue issued revised HB 5006 guidance. Two main differences of note in this revised guidance are:

1) The amount to be distributed by December 31, 2001 is the first year's estimated lost tax revenue instead of all four years estimated lost tax revenue. For Clackamas County, that amount is $116,831. At some point in the future, the Department of Revenue will issue additional guidance in 2022 regarding how to calculate lost tax revenue requests that would correspond to the 2021-22, 2022-23, and 2023-24 property tax years.

2) The Resolution is required to include a sworn statement that the requested amount represents estimated revenue lost in property tax years 2020-21 and 2021-22 due to the September 2021 wildfires.

Based on the DOR guidance, Clackamas County will receive $116,831 for property tax year 2020-21. Future grant amounts will not be known until additional DOR guidance is released.

RECOMMENDATION:
Staff respectfully recommends adoption of the attached Resolution.

Sincerely,

Tami Little

Tami Little
Assessor

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

In the Matter of Distribution of funds from 2021 House Bill 5006 for Reimbursement of Lost Property Tax Revenue Related to the 2020 Wildfires

Resolution No. _____

WHEREAS, the 2021 Oregon legislature passed House Bill 5006 providing funds for grants to counties for the reimbursement of lost property tax revenue related to the 2020 wildfires;

WHEREAS, distribution of the funds appropriated by the Oregon legislature is limited to counties included in Executive Order 20-60 that were impacted by the 2020 wildfires;

WHEREAS, Clackamas County has been designated as a county impacted by the 2020 wildfires and thus is entitled to reimbursement for lost tax revenue;

WHEREAS, House Bill 5006 requires the County to apply for its available funds and provide its Resolution which shall include the amount requested for tax year 2020-21, how the county will distribute the funds, a commitment to provide a follow-up report, and a sworn statement that the requested amount represents estimated revenue lost in the property tax years 2020-21 and 2021-22 due to the September 2020 wildfires;

WHEREAS, the Assessor and staff have reviewed House Bill 5006 and provided an overview of the measure to the Board of County Commissioners on November 2, 2021;

WHEREAS, 2021 House Bill provides for funds of $116,831 for tax year 2020-21 to be distributed to all Clackamas County property tax districts;

NOW, THEREFORE, IT IS HEREBY RESOLVED BY THE CLACKAMAS COUNTY BOARD OF COMMISSIONERS that:

1. Clackamas County approves and requests distribution of grant funds from 2021 House Bill 5006 to replace estimated lost property tax revenue due to the 2020 wildfires in the amount of $116,831 for the 2020-21 tax year, which will be distributed to Clackamas County property tax districts as follows:

2. Clackamas County will distribute the money to all taxing districts in the county using the 2020-21 tax year uniform distribution schedule;

3. Clackamas County commits to provide a report to the Oregon Department of Revenue per its guidance showing the amounts distributed to the taxing districts; and

4. Clackamas County swears that the amount requested represents estimated revenue lost in property tax year 2020-21 due to the September 2020 wildfires.

   We also swear the lost revenue estimate for tax year 2021-22 is $144,347 due to the September 2020 wildfires and will be requested and distributed in 2022 following further guidance from the Department of Revenue.

DATED this __ day of ___ 2021.

CLACKAMAS COUNTY BOARD OF COMMISSIONERS

_____
Chair

_____
Recording Secretary

Dave DeVore
Interim TS Director

Technology Services

121 Library Court Oregon City, OR 97045

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Contract with Northstar Electrical Contractors, Inc. for the CBX Fiber WCCCA Connection

Purpose/Outcomes	Provide a CBX Fiber connection in partnership with the City of Hillsboro.
Dollar Amount and Fiscal Impact	Contract Total Value: $179,000.00. The invoice will be paid from the City of Hillsboro funds.
Funding Source	City of Hillsboro through a Joint procurement agreement.
Duration	Contract execution through June 30, 2022 With option for three (3) additional one (1) year renewals.
Previous Board Action	The Board previously approved an agreement with the City of Hillsboro for this new dark fiber agreement on August 5, 2021.
Strategic Plan Alignment	Direct support for County and Technology Service initiatives for: - Build a strong infrastructure - Build public trust through good government
Counsel Review	AN, November 4, 2021
Procurement Review	Was this project processed through Procurement? Yes.
Contact Person	Duke Dexter, IS Project Coordinator, 503-722-6663
Contract No.	4629

Background:
Washing County Consolidated Communications Agency (WCCCA) is one of four 911 centers in the MAJCS (Metro Area Joint CAD System) that shares a regional Computer Aided Dispatch (CAD) system which is the brains for all 911 centers. Clackamas County (C-COM), Lake Oswego Communications (LOCOM) and Columbia 911 (C911) are all partners of this CAD system. It is important that the CAD Network be built on dark fiber that is owned and not commercially shared so that none of these 911 centers lose connectivity to all 4 of the partners involved in this project.

The four 911 centers have sought to ensure the highest levels of redundancy and resilience to provide a stable CAD environment, not only for the 911 partners, but also for all of the police, fire and Emergency Medical Service (EMS) providers who rely on the life safety information shared by 911 callers within these four jurisdictions.

This is a joint procurement project for connecting fiber in the City of Hillsboro. Clackamas Broadband eXchange (CBX) will provide the project management oversight of the entire construction process including, but not limited to, design/engineering, procurement of construction materials, oversight of construction and quality control. CBX will review all invoice from Northstar Electric and then pass them along to the City of Hillsboro for payment. The City of Hillsboro will pay all approved invoices from this project. When the new fiber project is complete, the City of Hillsboro will own, manage and maintain the new fiber infrastructure.

The project work is anticipated to begin immediately following contract signing. Substantial completion will be 60 days from the issuance of the notice to proceed, with final completion 90 days from notice to proceed.

Procurement Process:
This project advertised as a joint procurement with the City of Hillsboro pursuant to ORS 279A.210. The project advertised on September 16, 2021. Bids were publicly opened on October 12, 2021. The project received two (2) bids: Northstar Electrical Contractors, Inc., $174,000.00, and Henkels & McCoy, Inc., $191,244.00. After review of the bids, Northstar Electrical Contracts, Inc. was determined to be the lowest responsive bidder.

Recommendation:
Staff respectfully recommends that the Board approve and sign this joint public improvements contract with the City of Hillsboro and Northstar Electrical Contractors, Inc. for the WCCCA Fiber Connection.

Sincerely,

Dave Devore,
Interim TS Director

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT
Contract #4629

This Public Improvement Contract (the "Contract") is a joint procurement pursuant to ORS 279A.210, and is made by and between the Clackamas County, a political subdivision of the State of Oregon, and the City of Hillsboro, hereinafter called "Owner," and **Northstar Electrical Contractors Inc.**, 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: **#2021-79 CBX Fiber WCCCA Connection**

1. Contract Price, Contract Documents and Work.
The Contractor, in consideration of the sum of **one hundred seventy-nine thousand dollars ($179,000.00)** (the "Contract Price"), to be paid to the Contractor by the City of Hillsboro 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 Clackamas County General Conditions for Public Improvement Contracts (1/1/2020) ("General Conditions") 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
- Supplemental General Conditions
- Payroll and Certified Statement Form
- Instructions to Bidders
- Bid Bond
- Public Improvement Contract Form
- Clackamas County General Conditions (1/1/2020)
- Prevailing Wage Rates
- Plans, Specifications and Drawings

"Owner," as used in the Clackamas County General Conditions (1/1/2020) ("General Conditions") shall also include the City of Hillsboro.

2. Representatives.
Contractor has named Jesse Culp 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 Duke Dexter and Michael Lucas 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. Duke Dexter shall serve as Owner's project manager ("Project Manager") for the project.

☐ 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: Jesse Culp shall be the Contractor's project executive, and will provide oversight and guidance throughout the project term.

Project Manager: Robbie Federico shall be the Contractor's project manager and will participate in all meetings throughout the project term.

Job Superintendent: Dave Elhard shall be the Contractor's on-site job superintendent throughout the project term.

Project Engineer: Adam Suminski 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: 60 days from NTP
FINAL COMPLETION DATE: 90 days from NTP

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.
In accordance with Section G.3.5 of the General Conditions, Contractor shall furnish proof of the required insurance naming Clackamas County and the City of Hillsboro as additional insured. Insurance certificates may be returned with the signed Contract or may be emailed to Procurement@clackamas.us.

6. Bonds. Contractor shall furnish the bonds required under the General Conditions. The bonds shall be for the benefit of both Clackamas County and the City of Hillsboro.

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. 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.

12. Responsibility for Taxes. Contractor is solely responsible for payment of any federal, state, or local taxes required as a result of the Contract or the Work including, but not limited, to payment of the corporate activity tax imposed under enrolled HB 3427 (2019 Oregon regular legislative session). Contractor may not include its federal, state, or local tax obligations as part of the cost to perform the Work.

13. Payments. Contractor payments will be handled as follows: progress payments will be submitted to the Project Manager for review and approval. Approved payment requests will be sent to the City of Hillsboro by the Project Manager where finalized payments will paid to the Contractor by the City of Hillsboro. Retainage withholdings, if any, and any other amounts authorized to be withheld under this Contract will be withheld by the City of Hillsboro. The City of Hillsboro is solely responsible for the payment of the Contract Price to

Contractor under this Contract. Contractor shall have no recourse against Clackamas County for any unpaid Contract Price amounts that may be due and owing.

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:
Northstar Electrical Contractors Inc.
11055 SW Clay Street
Sherwood, Oregon 97140

Contractor CCB # 90454 Expiration Date: 4/24/2023
Oregon Business Registry # 341312-84 Entity Type: DBC 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.

Northstar Electrical Contractors Inc.

11/3/21
Authorized Signature Date

Jesse Culp President
Name / Title Printed

Clackamas County

Chair Date

Recording Secretary

City of Hillsboro

DocuSigned by:
Robby Hammond
0FC2577717B047B...
Robby Hammond, City Manager

APPROVED AS TO FORM

County Counsel Date

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT OPPORTUNITY

Table of Contents

CLACKAMAS COUNTY
NOTICE OF PUBLIC IMPROVEMENT CONTRACT OPPORTUNITY

INVITATION TO BID #2021-79
CBX Fiber WCCCA Connection
September 16, 2021

Clackamas County ("County") and the city of Hillsboro are conducting a joint procurement pursuant to ORS 279A.210 through its Board of County Commissioners and will be accepting sealed bids for the **CBX Fiber WCCCA Connection** Project until **October 12, 2021, 2:00 PM,** Pacific Time, ("Bid Closing") at the following location:

DELIVER BIDS TO: Clackamas County Procurement Division via email to procurement@clackamas.us

Bidding Documents can be downloaded from the state of Oregon procurement website ("OregonBuys") at the following address: https://oregonbuys.gov/bso/view/login/login.xhtml, Document No.S-C01010-00000779.
Prospective Bidders will need to sign in to download the information and that information will be accumulated for a Plan Holder's List. Prospective Bidders are responsible for obtaining any Addenda from Website listed above.

Project Estimate: $250,000.00

Contact Information
Procurement Process and Technical Questions: Ryan Rice, rrice@clackamas.us.

Bids will be opened and publicly read aloud at the above Delivery address after the Bid Closing. Bid results will also be posted to the OregonBuys listing shortly after the opening.

Prevailing Wage
Prevailing Wage Rates requirements apply to this Project because the maximum compensation for all Owner-contracted Work is more than $50,000. Contractor and all subcontractors shall comply with the provisions of ORS 279C.800 through 279C.870, relative to Prevailing Wage Rates. The Bureau of Labor and Industries (BOLI) wage rates and requirements set forth in the following BOLI booklet (and any listed amendments to that booklet), which are incorporated herein by reference, apply to the Work authorized under this Agreement:

PREVAILING WAGE RATES for Public Works Contracts in Oregon, July 1, 2021, which can be downloaded at the following web address: http://www.oregon.gov/boli/WHD/PWR/Pages/pwr_state.aspx
The Work will take place in Clackamas County, Oregon.
Clackamas County encourages bids from Minority, Women, and Emerging Small Businesses.

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT

INSTRUCTIONS TO BIDDERS

Clackamas County Local Contract Review Board Rules ("LCRB Rules") govern this procurement process. LCRB Rules may be found at: http://www.clackamas.us/code/documents/appendixc.pdf. The Instructions to Bidders is applicable to the procurement process for Clackamas County, or any component unit thereof identified on the Notice of Public Improvement Contract Opportunity, herein after referred to as the "Owner."

Article 1. Scope of Work

The work contemplated under this contract with the Owner, includes all labor, materials, transportation, equipment and services necessary for, and reasonably incidental to, the completion of all construction work in connection with the project described in the Project Manual which includes, but is not necessarily limited to, the Notice of Public Improvement Contract Opportunity, Instructions to Bidders, Supplemental Instructions to Bidders, Bid Form, Bid Bond, Public Improvement Contract Form, Performance Bond, Payment Bond, Clackamas County General Conditions for Public Improvement Contracts (1/1/2020), Supplemental General Conditions, and Plans, Specifications and Drawings.

Article 2. Examination of Site and Conditions

Before making a Bid, the Bidder shall examine the site of the work and ascertain all the physical conditions in relation thereto. The Bidder shall also make a careful examination of the Project Manual including the plans, specifications, and drawings and other contract documents, and shall be fully informed as to the quality and quantity of materials and the sources of supply of the materials. Failure to take these steps will not release the successful Bidder from entering into the contract nor excuse the Bidder from performing the work in strict accordance with the terms of the contract at the price established by the Bid.

The Owner will not be responsible for any loss or for any unanticipated costs, which may be suffered by the successful Bidder, as a result of such Bidder's failure to be fully informed in advance with regard to all conditions pertaining to the work and the character of the work required, including site conditions. No statement made by an elected official, officer, agent, or employee of the Owner in relation to the physical or other conditions pertaining to the site of the work will be binding on the Owner, unless covered by the Project Manual or an Addendum.

Article 3. Interpretation of Project Manual and Approval of Materials Equal to Those Provided in the Specifications

If any Bidder contemplating submitting a Bid for the proposed contract is in doubt as to the true meaning of any part of the plans, specifications or forms of contract documents, or detects discrepancies or omissions, such Bidder may submit to the Architect (read "Engineer" throughout in lieu of Architect as appropriate) a written request for an interpretation thereof at least ten (10) calendar days prior to the date set for the Bid Closing.

When a prospective Bidder seeks approval of a particular manufacturer's material, process or item of equal value, utility or merit other than that designated by the Architect in the Project Manual, the Bidder may submit to the Architect a written request for approval of such substitute at least ten (10) calendar days prior to the date set for the Bid Closing. The prospective Bidder submitting the request will be responsible for its prompt delivery.

Requests of approval for a substitution from that specified shall be accompanied by samples, records of performance, certified copies of tests by

impartial and recognized laboratories, and such other information as the Architect may request.

To establish a basis of quality, certain processes, types of machinery and equipment or kinds of materials may be specified in the Project Manual either by description of process or by designating a manufacturer by name and referring to a brand or product designation or by specifying a kind of material. Whenever a process is designated or a manufacturer's name, brand or item designation is given, or whenever a process or material covered by patent is designated or described, it shall be understood that the words "or approved equal" follow such name, designation or description, whether in fact they do so or not.

Any interpretation of the Project Manual or approval of manufacturer's material will be made only by an Addendum duly issued. All Addenda will be posted to the ORPIN listing and will become a part of the Project Manual. The Owner will not be responsible for any other explanation or interpretation of the Project Manual nor for any other approval of a particular manufacturer's process or item for any Bidder.

When the Architect approves a substitution by Addendum, it is with the understanding that the Contractor guarantees the substituted article or material to be equal or better than the one specified.

Article 4. Security to Be Furnished by Each Bidder

Each Bid must be accompanied by either 1) a cashier's check or a certified check drawn on a bank authorized to do business in the State of Oregon, or 2) a Bid bond described hereinafter, executed in favor of the Owner, for an amount equal to ten percent (10%) of the total amount Bid as a guarantee that, if awarded the contract, the Bidder will execute the contract and provide a performance bond and payment bond as required. The successful Bidder's check or Bid bond will be retained until the Bidder has entered into a contract satisfactory to Owner and furnished a one hundred percent (100%) performance bond and one hundred percent (100%) payment bond. The Owner reserves the right to hold the Bid security as described in Article 10 hereof. Should the successful Bidder fail to execute and deliver the contract as provided for in Article 12 hereof, including a satisfactory performance bond and payment bond within twenty (20) calendar days after the Bid has been accepted by the Owner, then the contract award made to such Bidder may be considered canceled and the Bid security may be forfeited as liquidated damages at the option of the Owner. The date of the acceptance of the Bid and the award of the contract as contemplated by the Project Manual shall mean the date of acceptance specified in the Notice of Intent to Award.

Article 5. Execution of Bid Bond

Should the Bidder elect to utilize a Bid bond as described in Article 4 in order to satisfy the Bid security requirements, such form must be completed in the following manner:

A. Bid bonds must be executed on the County forms, which will be provided to all prospective Bidders by the Owner.

B. The Bid bond shall be executed on behalf of a bonding company licensed to do business in the State of Oregon.

C. In the case of a sole individual, the bond need only be executed as principal by the sole individual. In the case of a partnership, the bond must be executed by at least one of the partners. In the case of a corporation, the bond must be executed by stating the official name of the corporation under which is placed the signature of an officer authorized to sign on behalf of the corporation followed by such person's official capacity, such as president, etc. The corporation seal should then be affixed to the bond.

D. The name of the surety must be stated in the execution over the signature of its duly authorized attorney-in-fact and accompanied by the seal of the surety corporation.

Article 6. Execution of the Bid Form

Each Bid shall be made in accordance with: (i) the sample Bid Form accompanying these instructions; (ii) the appropriate signatures for a sole individual, partnership, corporation or limited liability corporation shall be added as noted in Article 5C above; (iii) numbers pertaining to base Bids shall be stated both in writing and in figures; and (iv) the Bidder's address shall be typed or printed.

The Bid Form relates to Bids on a specific Project Manual. Only the amounts and information asked for on the Bid Form furnished will be considered as the Bid. Each Bidder shall Bid upon the work exactly as specified and provided in the Bid Form. The Bidder shall include in the Bid a sum to cover the cost of all items contemplated by the Contract. The Bidder shall Bid upon all alternates that may be indicated on the Bid Form. When Bidding on an alternate for which there is no charge, the Bidder shall write the words "No Charge" in the space provided on the Bid Form. If one or more alternates are shown on the Bid Form, the Bidder shall indicate whether each is "add" or "deduct."

Article 7. Prohibition of Alterations to Bid

Bids that are incomplete, or contain ambiguities or have differing conditions required by the Bidder, including requested changes or exceptions to the Public Improvement Contract form or other portions of the Project Manual, may be rejected in Owner's sole and absolute discretion.

Article 8. Submission of Bid

Each Bid shall be sealed in an envelope, properly addressed to the Owner, showing on the outside of the envelope the name of the Bidder and the name of the project. Bids will be received at the time and place stated in the Notice of Public Improvement Contract Opportunity.

Article 9. Bid Closing and Opening of Bids

All Bids must be received by the Owner at the place and time set for the Bid Closing. Any Bids received after the scheduled Bid Closing time for receipt of Bids will be rejected.

At the time of opening and reading of Bids, each Bid received will be publicly opened and read aloud, irrespective of any irregularities or informalities in such Bids.

Generally, Bid results will be posted to the Procurement Website within a couple hours of the opening.

Article 10. Acceptance or Rejection of Bids by Owner

Unless all Bids are rejected, the Owner will award a contract based on the lowest responsive Bid from a responsible Bidder. If that Bidder does not execute the contract, it will be awarded to the next lowest responsible Bidder or Bidders in succession.

The Owner reserves the right to reject all Bids and to waive minor informalities. The procedures for contract awards shall be in compliance with the provisions of the LCRB Rules in effect at that time.

The Owner reserves the right to hold the Bid and Bid security of the three lowest Bidders for a period of thirty (30) calendar days from and after the time of Bid opening pending award of the contract. Following award of the contract the Bid security of the three lowest Bidders may be held twenty (20) calendar days pending execution of the contract. All other Bids will be rejected and Bid security will be returned.

In determining the lowest Bidder, the Owner reserves the right to take into consideration any or all authorized base Bids as well as alternates or combinations indicated in the Bid Form.

If no Bid has been accepted within thirty (30) calendar days after the opening of the Bids, each of the three lowest Bidders may withdraw the Bid submitted and request the return of the Bid security.

Article 11. Withdrawal of Bid

At any time prior to the Bid Closing, a Bidder may withdraw its Bid. This will not preclude the

submission of another Bid by such Bidder prior to the time set for the Bid Closing.

After the time set for the Bid Closing, no Bidder will be permitted to withdraw its Bid within the time frames specified in Article 10 for award and execution, except as provided for in that Article.

Article 12. Execution of Contract, Performance Bond and Payment Bond

The Owner will provide the successful Bidder with contract forms within seven (7) calendar days after the completion of the award protest period. The Bidder is required to execute the contract forms as provided, including a performance bond and a payment bond from a surety company licensed to do surety business in the State of Oregon, within seven (7) calendar days after receipt of the contract forms. The contract forms shall be delivered to the Owner in the number called for and to the location as instructed by the Owner.

Article 13. Recyclable Products

Contractors will use recyclable products to the maximum extent economically feasible in the performance of the Contract.

Article 14. Clarification or Protest of the Solicitation Document or Specifications

Any request for clarification or protest of the solicitation document or specifications must be submitted in the manner provided for in the applicable section of the LCRB Rules to the Procurement Representative referenced in the Notice of Public Improvement Contract Opportunity.

A protest of the Solicitation Document must be received within seven (7) business days of the issuance of the Bid or within three (3) business days of issuance of an addendum.

Requests for clarification may be submitted no less than five (5) business days prior to the Bid Closing Date.

Article 15. Protest of Intent to Award

Owner will name the apparent successful Bidder in a "Notice of Intent to Award" letter. Identification of the apparent successful Bidder is procedural only and creates no right in the named Bidder to the award of the contract. Competing Bidders will be notified by publication of the Notice of Intent to Award on the Clackamas County Procurement Website of the selection of the apparent successful Bidder(s) and Bidders shall be given seven (7) calendar days from the date on the "Notice of Intent to Award" letter to review the file at the Procurement Division office and file a written protest of award, pursuant to C-049-0450. Any award protest must be in writing and must be delivered by hand delivery or mail to the Procurement Division Director at: Procurement Division, 2051 Kaen Road, Oregon City, OR 97045.

Article 16. Disclosure of First-Tier Subcontractors

Within two (2) working hours after the Bid Closing, all Bidders shall submit to the County a disclosure form identifying any first-tier subcontractors (those entities that would be contracting directly with the prime contractor) that will be furnishing labor and materials on the contract, if awarded, whose subcontract value would be equal to or greater than: (a) Five percent (5%) of the total contract price, but at least $15,000; or (b) $350,000, regardless of the percentage of the total contract price.

Disclosures may be submitted with the Bid or may be hand delivered to the Bid Closing address or emailed to procurement@clackamas.us.

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT

SUPPLEMENTAL INSTRUCTIONS TO BIDDERS

Project Name: #2021-79 CBX Fiber WCCCA Connection

The following modify the Clackamas County "Instructions to Bidders" for this Project. Where a portion of the Instructions to Bidders has been modified by these Supplemental Instructions to Bidders, the unaltered portions shall remain in effect.

1. **Closed buildings:** The County is requiring all bids for this project be electronically submitted. Complete Bids (including all attachments) must be received by the closing time and date 2:00 p.m. Pacific Time, October 12, 2021. The Bid must be emailed to the following address: **Procurement@clackamas.us. The email subject line must read "Bid for # #2021-79 CBX Fiber WCCCA Connection title."** Upon receiving of the bid, the County will send bidders an email confirmation acknowledging receipt. Bids delayed or lost by email system filtering or failures may be considered at Clackamas County's sole and absolute discretion.
   Bids will be publicly read aloud via the computer application, Zoom. Bidders will be allowed to video conference or listen by phone to the bid results. The projects Zoom meeting can be accessed via the information below:

Join Zoom Meeting
https://clackamascounty.zoom.us/j/82931908673?pwd=QzVmVTR1OUJVQUtoMWtGRXFGWnFlQT09

Meeting ID: 829 3190 8673
Passcode: 039012
One tap mobile
+16699006833,,82931908673# US (San Jose)
+12532158782,,82931908673# US (Tacoma)

Dial by your location
+1 669 900 6833 US (San Jose)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 408 638 0968 US (San Jose)
+1 312 626 6799 US (Chicago)
+1 646 876 9923 US (New York)
+1 301 715 8592 US (Washington DC)

**The Apparent Low bid results will be posted to the projects OPRIN listing as soon as possible following the bid opening.

2. **Good Faith Effort:** Clackamas County encourages participation in contracts by Historically Underrepresented Businesses. "Historically Underrepresented Businesses" are State of Oregon-certified and self-identified minority, women and emerging small business as well as firms that are certified federally or by another state or entity with substantially similar requirements as the State of Oregon.

   Bidders must perform Good Faith Effort (defined below) and submit **Form 1 and Form 2** for the Bidders Bid to be considered responsive. **Form 1 and Form 2** must be submitted within **two (2) hours** after the Closing Date and Time. Form 1 and Form 2 may be submitted by hand delivery to the location the Bid was due or may email the completed Forms to Procurement@clackamas.us. "Good Faith Effort" is a requirement of a prime contractor to reach out to at least three Historically Underrepresented Business Subcontractors for each division of work that will be subcontracted out and to complete the required forms. If fewer than three Historically Underrepresented Business Subcontractors are reasonably available for a particular division of work, the Bidder must specifically note the reason for there being fewer than three contacts. The outreach should be performed with sufficient time to give the subcontractors at least 5 calendar days to respond to the opportunity. Form 3, which documents the actual amount of subcontractors on the project, must be submitted with the project final pay application. Compliance with the Good Faith Effort and submission of Forms 1, 2 and 3 is a contractual requirement for final payment.

   The sufficiency of the documentation or the performance of Good Faith Effort shall be in the sole and absolute determination of Clackamas County. Only those Bidders that Clackamas County has determined have not sufficiently performed Good Faith Effort shall have protest rights of the determination for such Bidder. No Bidder shall have protest rights of the sufficiency of any other Bidder completing Good Faith Effort.

CLACKAMAS COUNTY
GOOD FAITH EFFORT
SUBCONTRACTOR AND SELF-PERFORMED WORK LIST
(FORM 1)

Prime Contractor Name: **Total Contract Amount:**

Project Name: #2021-79 CBX
Fiber WCCCA Connection

PRIME SELF-PERFORMING: Identify below **ALL** GFE Divisions of Work (DOW) to be self-performed. Good Faith Efforts are otherwise required.

DOW BIDDER WILL SELF-PERFORM	***(GFE not required)***
all	

PRIME CONTRACTOR SHALL DISCLOSE AND LIST ALL SUBCONTRACTORS, including those Minority-owned, Woman-owned, and Emerging Small Businesses ("M/W/ESB") that you intend to use on the project. Hand delivery to Procurement, 2051 Kaen Road, Oregon City, OR 97045 or email to procurement@clackamas.us within 2 hours of the BID/Quote Closing Date/Time

LIST ALL SUBCONTRACTORS BELOW Use **correct legal name** of Subcontractor (No Assumed Business Names)	**Division of Work** (Painting, electrical, landscaping, etc.) List **ALL** DOW performed by Subcontractors	**DOLLAR AMOUNT OF SUBCONTRACT**	If Certified or self-reporting MBE/WBE/ESB Subcontractor Check box ☑		
			MBE	WBE	ESB
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐

CLACKAMAS COUNTY
GOOD FAITH EFFORT
M/W/ESB CONTACT / BIDS RECEIVED LOG
(FORM 2)

Prime Contractor:

Project: #2021-79
CBX Fiber WCCCA Connection

Prime Contractor must contact or endeavor to contact at least 3 M/W/ESB Subcontractors for each Division of Work. Prime Contractor shall record its contacts with M/W/ESB Subcontractors through use of this log (or equivalent) entering all required information. All columns shall be completed where applicable. Additional forms may be copied if needed.

NAME OF M/W/ESB SUBCONTRACTOR	Divisions of Work (Painting, electrical, landscaping, etc.)	Date Solicitation Letter / Fax Sent	PHONE CONTACT		BID ACTIVITY Check Yes or No			REJECTED BIDS (if bid received & not used)		Notes
			Date of Call	Person Receiving Call	Will Bid	Bid Received	Bid Used	Bid Amount	Reason Not Used (Price, Scope or Other. If Other, explain in Notes>>)	
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			

CLACKAMAS COUNTY
GOOD FAITH EFFORT
PROJECT COMPLETION REPORT
(FORM 3)

Prime Contractor Name: **Total Contract Amount:**

Project Name: #2021-79 CBX Fiber WCCCA Connection

Complete this form and submit with your request for final payment upon the project completion. Please list all subcontractors used for the project. Use additional sheets as necessary.

LIST ALL SUBCONTRACTORS BELOW Use **correct legal name** of Subcontractor (No Assumed Business Names)	**Division of Work** (Painting, electrical, landscaping, etc.) List **ALL** DOW performed by Subcontractors	**FINAL DOLLAR AMOUNT OF SUBCONTRACT**	If Certified or self-reported MBE/WBE/ESB Subcontractor Check box ✓		
			MBE	WBE	ESB
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐
Name **Address** **City/St/Zip** **Phone#** **OCCB#**			☐	☐	☐

BY SIGNING BELOW, I HEREBY CERTIFY THAT THE ABOVE LISTED FIRMS HAVE BEEN UTILIZED BY OUR COMPANY IN THE AMOUNTS REPRESENTED ABOVE AND THAT THE INFORMATION CONTAINED HEREIN IS COMPLETE AND ACCURATE. .

______________________________________ ______________

Authorized Signature of Contractor Representative Date

CLACKAMAS COUNTY

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT

BID BOND

Project Name: #2021-79 CBX Fiber WCCCA Connection

We, NORTHSTAR ELECTRICAL CONTRACTORS, INC., as "Principal,"
(Name of Principal)

and MARKEL INSURANCE COMPANY, an ILLINOIS Corporation,
(Name of Surety)

authorized to transact Surety business in Oregon, as "Surety," hereby jointly and severally bind ourselves, our respective heirs, executors, administrators, successors and assigns to pay unto Clackamas County and the City of Hillsboro ("Obligee") the sum of ($ (**10%**))

NOT TO EXCEED TEN PERCENT OF AMOUNT BID** dollars.

WHEREAS, the condition of the obligation of this bond is that Principal has submitted its proposal or bid to an agency of the Obligee in response to Obligee's procurement document (No2021-79) for the project identified above which proposal or bid is made a part of this bond by reference, and Principal is required to furnish bid security in an amount equal to ten (10%) percent of the total amount of the bid pursuant to the procurement document.

NOW, THEREFORE, if the Obligee shall accept the bid of the Principal and the Principal shall enter into a Contract with the Obligee in accordance with the terms of such bid, and give such bond or bonds as may be specified in the bidding or Contract Documents with good and sufficient surety for the faithful performance of such Contract and for the prompt payment of labor and material furnished in the prosecution thereof, or in the event of the failure of the Principal to enter such Contract and give such bond or bonds, if the Principal shall pay to the Obligee the difference not to exceed the penalty hereof between the amount specified in said bid and such larger amount for which the Obligee may in good faith contract with another party to perform the Work covered by said bid, then this obligation shall be null and void, otherwise to remain in full force and effect.

IN WITNESS WHEREOF, we have caused this instrument to be executed and sealed by our duly authorized legal representatives this 11th day of OCTOBER, 2021.

Principal: NORTHSTAR ELECTRICAL CONTRACTORS, INC.

By: _____
Signature

President
Official Capacity

Attest: _____
Corporation Secretary

Surety: MARKEL INSURANCE COMPANY

By: Attorney-In-Fact , ROBIN BAIRD

Robin Baird
Name

2103 CITY WEST BLVD STE 1300
Address

HOUSTON TX 77042
City State Zip

541-741-0550
Phone

541-741-1674
Fax

POA# 3710043

JOINT LIMITED POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That SureTec Insurance Company, a Corporation duly organized and existing under the laws of the State of Texas and having its principal office in the County of Harris, Texas and Markel Insurance Company (the "Company"), a corporation duly organized and existing under the laws of the state of Illinois, and having its principal administrative office in Glen Allen, Virginia, does by these presents make, constitute and appoint:

Michelle Bench, Robin Baird, Kyle Hudson, Keith Yam, Ken Price, William Kaufmann

Their true and lawful agent(s) and attorney(s)-in-fact, each in their separate capacity if more than one is named above, to make, execute, seal and deliver for and on their own behalf, individually as a surety or jointly, as co-sureties, and as their act and deed any and all bonds and other undertaking in suretyship provided, however, that the penal sum of any one such instrument executed hereunder shall not exceed the sum of:

Fifty Million and 00/100 Dollars ($50,000,000.00)

This Power of Attorney is granted and is signed and sealed under and by the authority of the following Resolutions adopted by the Board of Directors of SureTec Insurance Company and Markel Insurance Company:

"RESOLVED, That the President, any Senior Vice President, Vice President, Assistant Vice President, Secretary, Assistant Secretary, Treasurer or Assistant Treasurer and each of them hereby is authorized to execute powers of attorney, and such authority can be executed by use of facsimile signature, which may be attested or acknowledged by any officer or attorney, of the company, qualifying the attorney or attorneys named in the given power of attorney, to execute in behalf of, and acknowledge as the act and deed of the SureTec Insurance Company and Markel Insurance Company, as the case may be, all bond undertakings and contracts of suretyship, and to affix the corporate seal thereto."

IN WITNESS WHEREOF, Markel Insurance Company and SureTec Insurance Company have caused their official seal to be hereunto affixed and these presents to be signed by their duly authorized officers on the 3rd day of September , 2021 .

SureTec Insurance Company

By: _____
Michael C. Keimig, President

Markel Insurance Company

By: _____
Lindey Jennings, Vice President

State of Texas
County of Harris:

On this 3rd day of September , 2021 A. D., before me, a Notary Public of the State of Texas, in and for the County of Harris, duly commissioned and qualified, came THE ABOVE OFFICERS OF THE COMPANIES, to me personally known to be the individuals and officers described in, who executed the preceding instrument, and they acknowledged the execution of same, and being by me duly sworn, disposed and said that they are the officers of the said companies aforesaid, and that the seals affixed to the proceeding instrument are the Corporate Seals of said Companies, and the said Corporate Seals and their signatures as officers were duly affixed and subscribed to the said instrument by the authority and direction of the said companies, and that Resolutions adopted by the Board of Directors of said Companies referred to in the preceding instrument is now in force.

IN TESTIMONY WHEREOF, I have hereunto set my hand, and affixed my Official Seal at the County of Harris, the day and year first above written.

XENIA CHAVEZ
Notary Public, State of Texas
Notary ID# 12911765-9
My Commission Expires
SEPTEMBER 10, 2024

By: _____
Xenia Chavez, Notary Public
My commission expires 9/10/2024

We, the undersigned Officers of SureTec Insurance Company and Markel Insurance Company do herby certify that the original POWER OF ATTORNEY of which the foregoing is a full, true and correct copy is still in full force and effect and has not been revoked.

IN WITNESS WHEREOF, we have hereunto set our hands, and affixed the Seals of said Companies, on the 11th day of OCTOBER , 2021 .

SureTec Insurance Company

By: _____
M. Brent Beaty, Assistant Secretary

Markel Insurance Company

By: _____
Andrew Marquis, Assistant Secretary

Any Instrument Issued in excess of the penalty stated above is totally void and without any validity. 3710043
For verification of the authority of this Power you may call (713)812-0800 on any business day between 8:30 AM and 5:00 PM CST.

CLACKAMAS COUNTY

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT

BID FORM

PROJECT: #2021-79 CBX Fiber WCCCA Connection
BID CLOSING: October 12, 2021, 2:00 PM, Pacific Time
BID OPENING: October 12, 2021, 2:05 PM, Pacific Time

FROM: NorthStar Electrical Contractors, Inc.
Bidder's Name (must be full legal name, not ABN/DBA)

TO: Clackamas County
Procurement Division – procurement@clackamas.us

1. Bidder is (*check one of the following and insert information requested*):

____a. An individual; or

____b. A partnership registered under the laws of the State of _____; or

__✓__c. A corporation organized under the laws of the State of Oregon; or

____d. A limited liability corporation organized under the laws of the State of _____;

and authorized to do business in the State of Oregon hereby proposes to furnish all material and labor and perform all work hereinafter indicated for the above project in strict accordance with the Contract Documents for the Basic Bid as follows:

One hundred seventy four thousand Dollars ($ 174,000)

and the Undersigned agrees to be bound by the following documents:

- Notice of Public Improvement Contract Opportunity
- Instructions to Bidders
- Bid Bond
- Public Improvement Contract Form
- Clackamas County General Conditions
- Prevailing Wage Rates
- Plans, Specifications and Drawings
- Supplemental Instructions to Bidders
- Bid Form
- Performance Bond and Payment Bond
- Supplemental General Conditions
- Payroll and Certified Statement Form

- ADDENDA numbered 0 through 0, inclusive *(fill in blanks)*

2. The Undersigned proposes to add to or deduct from the Base Bid indicated above the items of work relating to the following Alternate(s) as designated in the Specifications:

ALTERNATE #1: Directional Rock Bore 2" SDR13.5 HDPE Rock Adder- Per Linear Foot — ADD: $ 12

ALTERNATE #2: Directional Rock Bore 1" SDR13.5 HDPE Adder- Per Linear Foot — ADD: $ 12

3. The Undersigned proposes to add to or deduct from the Base Bid indicated above the items or work relating to the following Unit Price(s) as designated in the Specifications, for which any adjustments in the Contract amount will be made in accordance with Section D of the Clackamas County General Conditions:

UNIT PRICE #1: Traffic Control — ADD $ 1400

UNIT PRICE #2: Potholing of Existing Utilities — ADD $ 530

UNIT PRICE #3: Full Panel Concrete Restoration — ADD $ 1800

4. The work shall be completed within the time stipulated and specified in the contract documents.

5. Accompanying herewith is Bid Security which is equal to ten percent (10%) of the total amount of the Basic Bid, plus the total sum of all Alternatives (if any).

6. The Undersigned agrees, if awarded the Contract, to execute and deliver to Clackamas County, within twenty (20) calendar days after receiving the Contract forms, a Contract Form, and a satisfactory Performance Bond and Payment Bond each in an amount equal to one hundred percent (100%) of the Contract sum, using forms provided by the Owner. The surety requested to issue the Performance Bond and Payment Bond will be:

Markel Insurance Company.

(name of surety company - not insurance agency)

The Undersigned hereby authorizes said surety company to disclose any information to the Owner concerning the Undersigned's ability to supply a Performance Bond and Payment Bond each in the amount of the Contract.

7. The Undersigned further agrees that the Bid Security accompanying the Bid is left in escrow with Clackamas County; that the amount thereof is the measure of liquidated damages which the Owner will sustain by the failure of the Undersigned to execute and deliver the above-named Contract Form, Performance Bond and Payment Bond, each as published, and that if the Undersigned defaults in either executing the Contract Form or providing the Performance Bond and Payment Bond within twenty (20) calendar days after receiving the Contract forms, then the Bid

Security shall become the property of the Owner at the Owner's option; but if the Bid is not accepted within thirty (30) calendar days of the time set for the opening of the Bids, or if the Undersigned executes and timely delivers said Contract Form, Performance Bond and Payment Bond, the Bid Security shall be returned.

8. The Undersigned certifies that: (i) This Bid has been arrived at independently and is being submitted without collusion with and without any agreement, understanding, or planned common course of action with any other vendor of materials, supplies, equipment or services described in the invitation to bid designed to limit independent bidding or competition; and (ii) the contents of the Bid have not been communicated by the Undersigned or its employees or agents to any person not an employee or agent of the Undersigned or its surety on any Bond furnished with the Bid and will not be communicated to such person prior to the official opening of the Bid.

9. The undersigned ☒ **HAS,** ☐ **HAS NOT** (*check one*) paid unemployment or income taxes in Oregon within the past 12 months and ☒ **DOES,** ☐ **DOES NOT** (*check one*) a business address in Oregon. The undersigned acknowledges that, if the selected bidder, that the undersigned will have to pay all applicable taxes and register to do business in the State of Oregon before executing the Contract Form.

10. The Undersigned agrees, if awarded a contract, to comply with the provisions of ORS 279C.800 through 279C.870 pertaining to the payment of the prevailing rates of wage.

11. Contractor's CCB registration number is 90454. As a condition to submitting a bid, a Contractor must be registered with the Oregon Construction Contractors Board in accordance with ORS 701.035 to 701.055, and disclose the registration number. Failure to register and disclose the number will make the bid unresponsive and it will be rejected, unless contrary to federal law.

12. The successful Bidder hereby certifies that all subcontractors who will perform construction work as described in ORS 701.005(2) were registered with the Construction Contractors Board in accordance with ORS 701.035 to 701.055 at the time the subcontractor(s) made a bid to work under the contract.

13. The successful Bidder hereby certifies that, in compliance with the Worker's Compensation Law of the State of Oregon, its Worker's Compensation Insurance provider is SAIF, Policy No. 793309, and that Contractor shall submit Certificates of Insurance as required.

14. Contractor's Key Individuals for this project (supply information as applicable):

Project Executive: Jesse Culp, Cell Phone: 503-969-9219,
Project Manager: Robbie Federico, Cell Phone: 503-307-9087,
Job Superintendent: Dave Elhard, Cell Phone: 503-969-3471,
Project Engineer: Adam Sumiński, Cell Phone: 503-514-0271.

15. The Undersigned certifies that it has not discriminated against minority, women, or emerging small businesses in obtaining any subcontracts for this project.

16. The Undersigned certifies that it has a drug testing program in accordance with ORS 279C.505.

REMINDER: Bidder must submit the below First-Tier Subcontractor Disclosure Form.

By signature below, Contractor agrees to be bound by this Bid.

NAME OF FIRM: North Star Electrical Contractors, Inc.

ADDRESS: 11055 SW Clay Street
Sherwood, OR 97140

TELEPHONE NO: 503-612-0840

EMAIL: jesse.culp@northstarelect.com

SIGNATURE 1) _____
Sole Individual

or 2) _____
Partner

or 3) _____
Authorized Officer or Employee of Corporation

* * * * * *END OF BID* * * * * *

FIRST-TIER SUBCONTRACTOR DISCLOSURE FORM
PROJECT: #2021-79
CBX Fiber WCCCA Connection

BID OPENING: October 12, 2021, 2:00 PM, Pacific Time

Failure to submit this Form by the disclosure deadline will result in a nonresponsive bid.

INSTRUCTIONS:

This First-Tier Subcontractor Disclosure Form ("Form") must be submitted and received at the location specified in the Notice of Public Improvement Contract Opportunity on the advertised Bid Closing, and within two working hours after the advertised Bid Closing Time.

The Form may be mailed, hand-delivered or emailed to: Procurement@clackamas.us. It is the responsibility of Bidders to submit this Form and any additional sheets with the Project name clearly marked on the envelope or the subject line of the email.

Subcontractor lists may be submitted with the bid in the same envelope or email at the Bid Closing date and time. Subcontractor lists **MUST** be submitted within **two (2) hours** of the Bid Closing date and time.

List below the name of each subcontractor that will be furnishing labor, or labor and materials, for which disclosure is required, the category of work that the subcontractor will be performing, and the dollar value of the subcontract. Enter **"NONE"** if the value of the project bid is less than $100,000 or there are no subcontractors that need to be disclosed. ATTACH ADDITIONAL SHEETS IF NECESSARY.

	SUBCONTRACTOR NAME	DOLLAR VALUE	CATEGORY OF WORK
1.	None		
2.			
3.			
4.			
5.			
6.			

The above listed first-tier subcontractor(s) are providing labor, or labor and material, with a Dollar Value equal to or greater than:

a) 5% of the total Contract Price, but at least $15,000. If the Dollar Value is less than $15,000 do not list the subcontractor above; or
b) $350,000 regardless of the percentage of the total Contract Price.

Firm Name: North Star Electrical Contractors, Inc.

Bidder Signature: [signature] Phone # 503-612-0840

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT SUPPLEMENTAL GENERAL CONDITIONS

PROJECT: #2021-79 CBX Fiber WCCCA Connection

The following modifies the October 13, 2021 Clackamas County General Conditions for Public Improvement Contracts ("County General Conditions") for this Contract. Except as modified below, all other terms and conditions of the County General Conditions shall remain in effect.

1. Permits

Section B.4-Permits of the County General Conditions is hereby deleted in it is entirety and replaced with the following:

> **B.4 PERMITS**
> The City and County shall obtain and pay for all necessary project permits. Contractor shall be responsible for all violations of the law, in connection with the construction or caused by obstructing streets, sidewalks or otherwise. Contractor shall give all requisite notices to public authorities.

2. Good Faith Effort

As a condition of Contractor being awarded a Contract for this Project, Contractor must complete Good Faith Effort outreach and documentation as described in the Supplemental Instructions to Bidders of the Solicitation Document.

The Contractor may not change who is performing each Division of Work identified in Form 1 of the Good Faith Effort without the express written advance approval of Owner. This includes substituting identified subcontractors, self-performance of a Division of Work that was identified to be performed by a subcontractor, or the Contractor subcontracting a Division of Work that was identified to be self-performed by the Contractor.

Contractor shall be required to submit the completed Form 3 with its final pay application as a condition of final payment.

CLACKAMAS COUNTY GENERAL CONDITIONS FOR PUBLIC IMPROVEMENT CONTRACTS
October 13, 2021

INSTRUCTIONS: The attached **Clackamas County General Conditions for Public Improvement Contracts ("County General Conditions")** apply to all designated Public Improvement contracts. Changes to the County General Conditions (including any additions, deletions or substitutions) should only be made by attaching Public Improvement Supplemental General Conditions. The text of these County General Conditions should not otherwise be altered.

TABLE OF SECTIONS

CLACKAMAS COUNTY GENERAL CONDITIONS FOR PUBLIC IMPROVEMENT CONTRACTS ("County General Conditions")

SECTION A
GENERAL PROVISIONS

A.1 DEFINITION OF TERMS

In the Contract Documents the following terms shall be as defined below:

APPLICABLE LAWS, means all federal, state and local laws, codes, rules, regulations and ordinances, as amended applicable to the Work, to the Contract, or to the parties individually.

APPROVED BY CONTRACTING AGENCY, for purposes of ORS 279C.570(2), means the date a progress payment is approved by the Clackamas County Treasurer's office.

ARCHITECT/ENGINEER, means the Person appointed by the Owner to make drawings and specifications and, to provide contract administration of the Work contemplated by the Contract to the extent provided herein or by supplemental instruction of Owner (under which Owner may delegate responsibilities to the Architect/Engineer), in accordance with ORS Chapter 671 (Architects) or ORS Chapter 672 (Engineers) and administrative rules adopted thereunder.

AVOIDABLE DELAYS, mean any delays other than Unavoidable Delays, and include delays that otherwise would be considered Unavoidable Delays but that: (a) Could have been avoided by the exercise of care, prudence, foresight, and diligence on the part of the Contractor or its Subcontractors; (b) Affect only a portion of the Work and do not necessarily prevent or delay the prosecution of other parts of the Work nor the completion of the whole Work within the Contract Time; (c) Do not impact activities on the accepted critical path schedule; and (d) Are associated with the reasonable interference of other contractors employed by the Owner that do not necessarily prevent the completion of the whole Work within the Contract Time.

BIDDER, means a bidder in connection with Instructions to Bidders or a proposer in connection with a Request for Proposals, or Solicitation Document. May also be referenced as "Offeror," "Quoter" or "Proposer" based on the type of Solicitation Document.

CHANGE ORDER, means a written order which, when fully executed by the Parties to the Contract, constitutes a change to the Contract Documents. Change Orders shall be issued in accordance with the changes provisions in Section D and, if applicable, establish a Contract Price or Contract Time adjustment. A Change Order shall not be effective until executed by both parties.

CLAIM, means a demand by Contractor pursuant to Section D.3 for review of the denial of Contractor's initial request for an adjustment of Contract terms, payment of money, extension of Contract Time or other relief, submitted in accordance with the requirements and within the time limits established for review of Claims in these County General Conditions.

CONTRACT, means the written agreement between the Owner and the Contractor comprised of the Contract Documents which describe the Work to be done and the obligations between the parties.

CONTRACT DOCUMENTS, means the Contract, County General Conditions, Supplemental General Conditions if any, Plans, Specifications, the accepted Offer, Solicitation Document and addenda thereto, Instructions to Offerors, and Supplemental Instructions to Offerors.

CONTRACT PERIOD, as set forth in the Contract Documents, means the total period of time beginning with the full execution of a Contract and, if applicable, the issuance of a Notice to Proceed and concluding upon Final Completion.

CONTRACT PRICE, means the total price reflected in the Contract.

CONTRACT TIME, means any incremental period of time allowed under the Contract to complete any portion of the Work as reflected in the Project schedule.

CONTRACTOR, means the Person awarded the Contract for the Work contemplated.

DAYS, are calendar days, including weekdays, weekends and holidays, unless otherwise specified.

DEFECTIVE WORK, means Work that is not completed in accordance with the Specifications or the requirements of the Contract.

DIRECT COSTS, means, unless otherwise provided in the Contract Documents: the cost of materials, including sales tax and the cost of delivery; cost of labor which shall only include the applicable prevailing wage and fringe benefit (if applicable, and if paid to or on behalf of the employee) rate plus a maximum of a twelve percent (12%) markup on the prevailing wage (but not the fringe benefit) to cover Contractor's labor burden including but not limited to social security, Medicare, unemployment insurance, workers' compensation insurance, sick leave pay; substantiated Project cost increases for specific insurance (including, without limitation, Builder's Risk Insurance and Builder's Risk Installation Floater) or bond premiums; rental cost of equipment, and machinery required for execution of the Work; and the additional costs of field personnel directly attributable to the Work; travel expense reimbursement only if specifically authorized and only to the extent allowable under the County Contractor Travel Reimbursement Policy, hereby incorporated by reference.

FINAL COMPLETION, means the final completion of all requirements under the Contract, including Contract Closeout as described in Section K but excluding Warranty Work as described in Section I.2, and the final payment and release of all retainage, if any.

FORCE MAJEURE, means an act, event or occurrence caused by fire, riot, war, acts of God, terrorism, nature, sovereign, or public enemy, strikes, freight embargoes or any other act, event or occurrence that is beyond the control of the party to the Contract who is asserting Force Majeure.

NOTICE TO PROCEED, means the official written notice from the Owner stating that the Contractor is to proceed with the Work defined in the Contract Documents.

OFFER, means a bid in connection with Instructions to Bidders or a proposal in connection with a Request for Proposals, or Solicitation Document to do the work stated in the Solicitation Document at the price quoted. May also be referenced as "Bid," "Quote," or "Proposal" based on the type of Solicitation Document.

OVERHEAD, means those items which may be included in the Contractor's markup (general and administrative expense and profit) and that shall not be charged as Direct Cost of the Work, including without limitation such Overhead expenses as wages or salary of personnel above the level of foreman (i.e., superintendents and project managers), labor rates and fringe benefits above the applicable prevailing wage and fringe benefit (if applicable, and if paid to or on behalf of the employee), Contractor's labor burden for fringe benefit if paid to the employee, expenses of Contractor's offices and supplies at the Project Site (e.g. job trailer) and at Contractor's principal place of business and including expenses of personnel staffing the Project Site office and Contractor's principal place of business, and Commercial General Liability Insurance and Automobile Liability Insurance.

OWNER, means, Clackamas County or any component unit thereof including Clackamas County Development Agency, Clackamas County Service District No. 1, Surface Water Management Agency of Clackamas County, Tri-City Service District, Water Environment Services, North Clackamas Parks and Recreation District, Clackamas County Extension & 4-H Service District, Library Service District of Clackamas County, Enhanced Law Enforcement District, and Clackamas County Service District No. 5. Owner may elect, by written notice to Contractor, to delegate certain duties to more than one agent, including without limitation, to an Architect/Engineer. However, nothing in these County General Conditions is intended to abrogate the separate design professional responsibilities of Architects under ORS Chapter 671 or of Engineers under ORS Chapter 672.

PERSON, means a natural person or entity doing business as a sole proprietorship, a partnership, a joint venture, a corporation, a limited liability company or partnership, a nonprofit, a trust, or any other entity possessing the legal capacity to contract.

PLANS, means the drawings which show the location, type, dimensions, and details of the Work to be done under the Contract.

PRODUCT DATA, means illustrations, standard schedules, performance charts, instructions, brochures, diagrams and other information furnished by the Contractor to illustrate materials or equipment for some portion of the Work.

PROJECT, means the total undertaking to be accomplished for Owner by architects/engineers, contractors, and other others, including planning, study, design, construction, testing, commissioning, start-up, of which the Work to be performed under the Contract Documents is a part.

PROJECT SITE, means the specific real property on which the Work is to be performed, including designated contiguous staging areas, that is identified in the Plans, Specifications and Drawings.

PUNCH LIST, means the list of Work yet to be completed or deficiencies which need to be corrected in order to achieve Final Completion of the Contract.

RECORD DOCUMENT, means the as-built Plans, Specifications, testing and inspection records, product data, samples, manufacturer and distributor/supplier warranties evidencing transfer of ownership to Owner, operational and maintenance manuals, shop drawings, correspondence, certificate(s) of occupancy, and other documents listed in Subsection B.9.1 of these County General Conditions, recording all Services performed.

SAMPLES, means physical examples which illustrate materials, equipment or workmanship and establish standards by which the Work will be judged.

SHOP DRAWINGS, means drawings, diagrams, schedules and other data specially prepared for the Work by the Contractor or a Subcontractor (including any subsubcontractor), manufacturer, supplier, or distributor to illustrate some portion of the Work.

SOLICITATION DOCUMENT, means an Invitation to Bid, Request for Proposals, Request for Quotes, or other written document issued by Owner that outlines the required Specifications necessary to submit an Offer.

SPECIFICATION, means any description of the physical or functional characteristics of the Work, or of the nature of a supply, service or construction item included in the Solicitation Document. Specifications may include a description of any requirement for inspecting, testing or preparing a supply, service or construction item for delivery and the quantities or qualities of materials to be furnished under the Contract. Specifications generally will state the results or products to be obtained and may, on occasion, describe the method and manner of doing the Work to be performed. Specifications may be incorporated by reference and/or may be attached to the Contract.

SUBCONTRACTOR, means a Person having a direct contract with the Contractor, or another Subcontractor of any tier, to perform one or more items of the Work.

SUBSTANTIAL COMPLETION, means the date when the Owner accepts in writing the construction, alteration or repair constituting the Work or any designated portion thereof as having reached that state of completion when it may be used or occupied for its intended purpose. Substantial Completion of facilities with operating systems occurs only after thirty (30) continuous Days of successful, trouble-free operation of the operating systems as provided in Section K.3.2.

SUBSTITUTIONS, means items that in function, performance, reliability, quality, and general configuration are the same or better than the product(s) specified. Substitutions also means the performance of the Work by a labor force other than what is submitted in the Offer.

SUPPLEMENTAL GENERAL CONDITIONS, means those conditions that remove from, add to, or modify these County General Conditions. Public Improvement Supplemental General Conditions may be included in the Solicitation Document or may be a separate attachment to the Contract.

UNAVOIDABLE DELAYS, mean delays other than Avoidable Delays that are: (a) to the extent caused by any actions of the Owner, or any other employee or agent of the Owner, or by a separate contractor employed by the Owner; (b) to the extent caused by any Project Site conditions which differ materially from the conditions that would normally be expected to exist and inherent to the construction activities defined in the Contract Documents; or (c) to the extent caused by Force Majeure acts, or events or occurrences.

WORK, means the furnishing of all materials, equipment, labor, transportation, services, incidentals, those permits and regulatory approvals not provided by the owner necessary to successfully complete any individual item or the entire Contract and the carrying out of duties and obligations imposed by the Contract Documents for the Project.

A.2 SCOPE OF WORK

The Work contemplated under the Contract includes all labor, materials, transportation, equipment and services for, and incidental to, the completion of all work in connection with the Project described in the Contract Documents. The Contractor shall perform all Work necessary so that the Project can be legally occupied and fully used for the intended use as set forth in the Contract Documents.

A.3 INTERPRETATION OF CONTRACT DOCUMENTS

A.3.1 Unless otherwise specifically defined in the Contract Documents, words which have well-known technical meanings or construction industry meanings are used in the Contract Documents in accordance with such recognized meanings. Contract Documents are intended to be complementary. Whatever is called for in one, is interpreted to be called for in all. However, in the event of conflicts or discrepancies among the Contract Documents, interpretations will be based on the following descending order of precedence:

(a) The Contract and any amendments thereto, including Change Orders, with those of later date having precedence over those of an earlier date;
(b) The Supplemental General Conditions;
(c) County General Conditions;
(d) Plans and Specifications;
(e) The Solicitation Document, and any addenda thereto.

A.3.2 In the case of an inconsistency between Plans and Specifications or within either document not clarified by addendum, the better quality or greater quantity of Work shall be provided in accordance with the Owner's interpretation in writing as determined in Owners sole discretion.

A.3.3 If the Contractor finds discrepancies in, or omissions from the Contract Documents, or if the Contractor is in doubt as to their meaning, the Contractor shall at once notify the Owner. Matters concerning and interpretation of requirements of the Contract Documents will be decided by the Owner in the Owner's sole discretion, who may delegate that duty in some instances to the Architect/Engineer. Responses to Contractor's requests for interpretation of Contract Documents will be made in writing by Owner (or the Architect/Engineer) within any time limits agreed upon or otherwise with reasonable promptness. Contractor shall not proceed without direction in writing from the Owner (or Architect/Engineer).

A.3.4 References to standard specifications, manuals, codes of any technical society, organization or association, to the laws or regulations of any governmental authority, whether such reference be specific or by implication, shall mean the latest standard specification, manual, code, laws or regulations in effect in the jurisdiction where the Project Site is located on the first published date of the Solicitation Document, except as may be otherwise specifically stated.

A.4 EXAMINATION OF PLANS, SPECIFICATIONS, AND PROJECT SITE

A.4.1 It is understood that the Contractor, before submitting an Offer, has made a careful examination of the Contract Documents; has become fully informed as to the quality and quantity of materials and the character of the Work required; and has made a careful examination of the location and conditions of the Work and the sources of supply for materials. The Owner will in no case be responsible for any loss or for any unanticipated costs that may be suffered by the Contractor as a result of the Contractor's failure to acquire full information in advance in regard to all conditions pertaining to the Work. No oral agreement or conversation with any officer, agent, or personnel of the Owner, or with the Architect/Engineer either before or after the execution of the Contract, shall affect or modify any of the terms or obligations herein contained. Contractor shall at all times be responsible for all utility locates regardless of the ownership of such utility infrastructure or service.

A.4.2 Should the Plans or Specifications fail to particularly describe the materials, kind of goods, or details of construction of any aspect of the Work, Contractor shall have the duty to make inquiry of the Owner and Architect/Engineer as to what is required prior to performance of the Work. Absent Specifications to the contrary, the materials or processes that would normally be used to produce first quality finished Work shall be considered a part of the Contract requirements.

A.4.3 Any design errors or omissions noted by the Contractor shall be reported promptly to the Owner, including without limitation, any nonconformity with Applicable Laws.

A.4.4 If the Contractor believes that adjustments to cost or Contract Time are involved because of clarifications or instructions issued by the Owner (or Architect/Engineer) in response to the Contractor's notices or requests for information, the Contractor must submit a written request to the Owner, setting forth the nature and specific extent of the request, including all time and cost impacts against the Contract as soon as possible, but no later than thirty (30) Days after receipt by Contractor of the clarifications or instructions issued. If the Owner denies Contractor's request for additional compensation, additional Contract Time, or other relief that Contractor believes results from the clarifications or instructions, the Contractor may proceed to file a Claim under Section D.3, Claims Review Process. If the Contractor fails to perform the obligations of Sections A.4.1 to A.4.3, the Contractor shall pay such costs and damages to the Owner as would have been avoided if the Contractor had performed such obligations.

A.4.5 If the Contractor believes that adjustments to cost or Contract Time are involved because of an Unavoidable Delay caused by differing Project Site conditions, the Contractor shall notify the Owner immediately of differing Project Site conditions before the area has been disturbed. The Owner will investigate the area and make a determination as to whether or not the conditions differ materially from either the conditions stated in the Contract Documents or those which could reasonably be expected in execution of this particular Contract. If Contractor and the Owner agrees that a differing Project Site condition exists, any adjustment to compensation or Contract Time will be determined based on the process set forth in Section D.2.2 for adjustments to or deletions from Work. If the Owner disagrees that a differing Project Site condition exists and denies Contractor's request for additional compensation or Contract Time, Contractor may proceed to file a Claim under Section D.3, Claims Review Process.

A.5 INDEPENDENT CONTRACTOR STATUS

The service or services to be performed under the Contract are those of an independent contractor as defined in ORS 670.600. Contractor represents and warrants that it is not an officer, employee or agent of the Owner as those terms are used in ORS 30.265.

A.6 RETIREMENT SYSTEM STATUS AND TAXES

Contractor represents and warrants that it is not a contributing member of the Public Employees' Retirement System and will be responsible for any federal or state taxes applicable to payment received under the Contract. Contractor will not be eligible for any benefits from these Contract payments of federal Social Security, employment insurance, workers' compensation or the Public Employees' Retirement System, except as a self-employed individual. Unless the Contractor is subject to backup withholding, Owner will not withhold from such payments any amount(s) to cover Contractor's federal or state tax obligations.

A.7 GOVERNMENT EMPLOYMENT STATUS

A.7.1 If this payment is to be charged against federal funds, Contractor represents and warrants that it is not currently employed by the Federal Government. This does not preclude the Contractor from holding another contract with the Federal Government.

SECTION B
ADMINISTRATION OF THE CONTRACT

B.1 OWNER'S ADMINISTRATION OF THE CONTRACT

B.1.1 The Owner shall administer the Contract as described in the Contract Documents throughout the term of the Contract, including the one-year period for correction of Work. The Owner will act as provided in the Contract Documents, unless modified in writing in accordance with other provisions of the Contract. In performing these tasks, the Owner may rely on the Architect/Engineer or other agents to perform some or all of these tasks.

B.1.2 The Owner may visit the Project Site at intervals appropriate to the stage of the Contractor's operations (1) to become generally familiar with and to keep the Owner informed about the progress and quality of the portion of the Work completed, (2) to endeavor to guard the Owner against defects and deficiencies in the Work, and (3) to determine in general if Work is being performed in a manner indicating that the Work, when fully completed, will be in accordance with the Contract Documents. The Owner will not

make exhaustive or continuous on-Project Site inspections to check the quality or quantity of the Work. Unless otherwise required in a Change Order, the Owner will neither have control over or charge of, nor be responsible for the construction means, methods, techniques, sequences or procedures, or for the safety precautions and programs in connection with the Work.

B.1.3 Except as otherwise provided in the Contract Documents or when direct communications have been specifically authorized, the Owner and Contractor shall communicate with each other within a reasonable time frame about matters arising out of or relating to the Contract. Communications by and with the Architect/Engineer's consultants shall be through the Architect/Engineer. Communications by and with Subcontractors and material suppliers shall be through the Contractor. Communications by and with separate contractors shall be through the Owner.

B.1.4 Based upon the Architect/Engineer's evaluations of the Contractor's Application for Payment, or unless otherwise stipulated by the Owner, the Architect/Engineer will review and certify the amounts due the Contractor and will issue Certificates for Payment in such amounts.

B.2 CONTRACTOR'S MEANS AND METHODS; MITIGATION OF IMPACTS

B.2.1 The Contractor shall supervise and direct the Work, using the Contractor's best skill and attention. The Contractor shall be solely responsible for and have control over construction means, methods, techniques, sequences and procedures and for coordinating all portions of the Work under the Contract, unless the Contract Documents give other specific instructions concerning these matters. If the Contract Documents give specific instructions concerning construction means, methods, techniques, sequences or procedures, the Contractor shall evaluate the Project Site safety thereof and, except as stated below, shall be fully and solely responsible for the Project Site safety of such means, methods, techniques, sequences or procedures.

B.2.2 The Contractor is responsible to protect and maintain the Work during the course of construction and to mitigate any adverse impacts to the Project, including those caused by authorized changes, which may affect cost, schedule, or quality.

B.2.3 The Contractor is responsible for the actions of all its personnel, laborers, suppliers, agents, and Subcontractors on the Project. The Contractor shall enforce strict discipline and good order among Contractor's employees and other persons carrying out the Work. The Contractor shall not permit employment of persons who are unfit or unskilled for the tasks assigned to them.

B.3 MATERIALS AND WORKMANSHIP

B.3.1 The intent of the Contract Documents is to provide for the construction and completion of every detail of the Work described. All Work shall be performed in a professional manner and, unless the means or methods of performing a task are specified elsewhere in the Contract Documents, Contractor shall employ methods that are generally accepted and used by the industry, in accordance with industry standards.

B.3.2 The Contractor is responsible to perform the Work as required by the Contract Documents. Defective Work shall be corrected at the Contractor's sole expense and within a reasonable time frame.

B.3.3 Work done and materials furnished may be subject to inspection and/or observation and testing by the Owner to determine if they conform to the Contract Documents. Inspection of the Work by the Owner does not relieve the Contractor of responsibility for the Work in accordance with the Contract Documents.

B.3.4 Contractor shall furnish adequate facilities, as required, for the Owner to have safe access to the Work including without limitation walkways, railings, ladders, tunnels, and platforms. Producers, suppliers, and fabricators shall also provide proper facilities and access to their facilities.

B.3.5 The Contractor shall furnish Samples of materials for testing by the Owner and include the cost of the Samples in the Contract Price.

B.4 PERMITS

Contractor shall obtain and pay for all necessary permits, licenses and fees, except for those specifically excluded in the Supplemental General Conditions, as required for the project. Contractor shall be responsible for all violations of the law. Contractor shall give all requisite notices to public authorities.

B.5 COMPLIANCE WITH GOVERNMENT REGULATIONS

B.5.1 Contractor shall comply with Applicable Laws, as amended pertaining to the Work and the Contract. Failure to comply with such requirements shall constitute a breach of Contract and shall be grounds for Contract termination. Without limiting the generality of the foregoing, Contractor expressly agrees to comply with the following, as applicable and as may be amended from time to time: (i) Title VI and VII of Civil Rights Act of 1964, as amended; (ii) Section 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Health Insurance Portability and Accountability Act of 1996; (iv) the Americans with Disabilities Act of 1990, as amended; (v) ORS Chapter 659A; as amended; (vi) all regulations and administrative rules established pursuant to any applicable laws; and (vii) all other applicable requirements of federal, state, county or other local government entity statutes, rules and regulations.

B.5.2 Contractor shall comply with all applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations, and

(a) Contractor shall not discriminate against Disadvantaged, Minority, Women or Emerging Small Business enterprises, as those terms are defined in ORS 200.005, or a business enterprise that is owned or controlled by or that employs a disabled veteran, as that term is defined in ORS 408.225, in the awarding of subcontracts.

(b) Contractor shall maintain, in current and valid form, all licenses and certificates required by Applicable Laws or the Contract when performing the Work.

B.5.3 Contractor shall certify that it shall not accept a bid from Subcontractors to perform Work unless such Subcontractors are registered with the Construction Contractors Board in accordance with ORS 701.021 at the time they submit their bids to the Contractor.

B.5.4 Contractor shall certify that each landscape contracting business, as defined in ORS 671.520(2), performing Work under the Contract holds a valid landscape construction professional license issued pursuant to ORS 671.560.

B.5.5 The following notice is applicable to Contractors who perform excavation Work. ATTENTION: Oregon law requires you to follow rules adopted by the Oregon Utility Notification Center. Those rules are set forth in OAR 952-001-0010 through OAR 952-001-0090. You may obtain copies of the rules by calling the center at (877) 668-4001.

B.5.6 Failure to comply with any or all of the requirements of B.5.1 through B.5.5 shall be a material breach of Contract and constitute

grounds for Contract termination. Damages or costs resulting from such noncompliance shall be the responsibility of Contractor.

B.5.7 The Contractor shall include in each subcontract those provisions required under ORS 279C.580.

B.5.8 Contractor shall comply with 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.

B.6 SUPERINTENDENCE

Contractor shall keep on the Project Site, during the progress of the Work, a competent superintendent and any necessary assistants who shall be satisfactory to the Owner and who shall represent the Contractor on the Project Site. Directions given to the superintendent by the Owner shall be confirmed in writing to the Contractor.

B.7 INSPECTION

B.7.1 Owner shall have access to the Work at all times.

B.7.2 Inspection of the Work will be made by the Owner at its discretion. The Owner will have authority to reject Work that does not conform to the Contract Documents in the Owner's sole discretion. Any Work found to be not in conformance with the Contract Documents, in the discretion of the Owner, shall be removed and replaced at the Contractor's expense.

B.7.3 Contractor shall make or obtain at the appropriate time all tests, inspections and approvals of portions of the Work required by the Contract Documents or by Applicable Laws or orders of public authorities having jurisdiction. Unless otherwise provided, the Contractor shall make arrangements for such tests, inspections and approvals with an independent testing laboratory or entity acceptable to the Owner, or with the appropriate public authority, and shall bear all related costs of tests, inspections and approvals. Tests or inspections conducted pursuant to the Contract Documents shall be made promptly to avoid unreasonable delay in the Work. The Contractor shall give the Owner timely notice of when and where tests and inspections are to be made so that the Owner may be present for such procedures. Required certificates of testing, inspection or approval shall, unless otherwise required by the Contract Documents, be secured by the Contractor and promptly delivered to the Owner.

B.7.4 As required by the Contract Documents, Work done or material used without required inspection or testing and/or without providing timely notice to the Owner may be ordered removed at the Contractor's expense.

B.7.5 If directed to do so by Owner or other permitting authority any time before the Work is accepted, the Contractor shall uncover portions of the completed Work for inspection. After inspection, the Contractor shall restore such portions of Work to the standard required by the Contract. If the Work uncovered is unacceptable or was done without required testing or inspection or sufficient notice to the Owner, the uncovering and restoration shall be done at the Contractor's expense. If the Work uncovered is acceptable and was done with sufficient notice to the Owner, the uncovering and restoration will be paid for pursuant to a Change Order.

B.7.6 If any testing or inspection reveals failure of the portions of the Work to comply with requirements established by the Contract Documents, all costs made necessary by such failure, including those of repeated procedures and compensation for the Owner's and Architect/Engineer's services and expenses, shall be at the Contractor's expense.

B.7.7 In Owner's sole discretion, it may authorize other interested parties to inspect the Work affecting their interests or property. Their right to inspect shall not make them a party to the Contract and shall not interfere with the rights of the parties of the Contract. Instructions or orders of such parties shall be transmitted to the Contractor, through the Owner.

B.8 SUBCONTRACTS AND ASSIGNMENT

B.8.1 Contractor shall require each Subcontractor, to the extent of the Work to be performed by the Subcontractor, to be bound by the terms and conditions of these General Conditions and Supplemental General Conditions, and to assume toward the Contractor all of the obligations and responsibilities which the Contractor assumes toward the Owner thereunder, unless (1) the same are clearly inapplicable to the subcontract at issue because of legal requirements or industry practices, or (2) specific exceptions are requested by Contractor and approved in writing by Owner. Where appropriate, Contractor shall require each Subcontractor to enter into similar agreements with sub-subcontractors at any level.

B.8.2 At Owner's request, Contractor shall submit to Owner prior to their execution either Contractor's form of subcontract, or the subcontract to be executed with any particular Subcontractor. If Owner disapproves such form, Contractor shall not execute the form until the matters disapproved are resolved to Owner's satisfaction. Owner's review, comment upon or approval of any such form shall not relieve Contractor of its obligations under this Agreement or be deemed a waiver of such obligations of Contractor.

B.8.3 Contractor shall not assign, sell, or transfer its rights, or delegate its responsibilities under the Contract, in whole or in part, without the prior written approval of the Owner. No such written approval shall relieve Contractor of any obligations of the Contract, and any transferee shall be considered the agent of the Contractor and bound to perform in accordance with the Contract Documents. Contractor shall remain liable as between the original parties to the Contract as if no assignment had occurred.

B.9 OWNER'S RIGHT TO DO WORK

Owner reserves the right to perform other or additional work at or near the Project Site with other agents than those of the Contractor. If such work takes place within or next to the Project Site, Contractor shall coordinate work with the other contractors or agents, cooperate with all other contractors or forces, carry out the Work in a way that will minimize interference and delay for all agents involved, place and dispose of materials being used so as not to interfere with the operations of another, and join the Work with the work of the others in an acceptable manner and perform it in proper sequence to that of the others. The Owner will resolve any disagreements that may arise between or among Contractor and the other contractors over the method or order of doing all work (including the Work). In case of unavoidable interference, the Owner will establish work priority (including the Work) in the Owner's sole discretion.

B.10 OTHER CONTRACTS

In all cases and at any time, the Owner has the right to execute other contracts related to or unrelated to the Work of the Contract. The Contractor of the Contract shall fully cooperate with any and all other contractors without additional cost to the Owner in the manner described in Section B.13.

B.11 ALLOWANCES

B.11.1 The Contractor shall include in the Contract Price all allowances stated in the Contract Documents. Items covered by allowances

shall be supplied for such amounts and by such persons or entities as the Owner may direct.

B.11.2 Unless otherwise provided in the Contract Documents:

(a) when finally reconciled, allowances shall cover the cost of the Contractor's materials and equipment delivered at the Project Site and all required taxes, less applicable trade discounts;

(b) Contractor's costs for unloading and handling at the Project Site, labor, installation costs, Overhead, profit and other expenses contemplated for stated allowance amounts shall be included in the Contract Price but not in the allowances;

(c) whenever costs are more than or less than allowances, the Contract Price shall be adjusted accordingly by Change Order. The amount of the Change Order shall reflect (i) the difference between actual costs and the allowances under Section B.17.2(a) and (ii) changes in Contractor's costs under Section B.17.2(b);

(d) Unless Owner requests otherwise, Contractor shall provide to Owner a proposed fixed price for any allowance work prior to its performance.

B.12 SUBMITTALS, SHOP DRAWINGS, PRODUCT DATA AND SAMPLES

B.12.1 The Contractor shall prepare and keep current, for the Architect's/Engineer's approval (or for the approval of Owner if approval authority has not been delegated to the Architect/Engineer), a schedule and list of submittals which is coordinated with the Contractor's construction schedule and allows the Architect/Engineer reasonable time to review submittals. Owner reserves the right to finally approve the schedule and list of submittals. Submittals include, without limitation, Shop Drawings, Product Data, and Samples.

B.12.2 Shop Drawings, Product Data, Samples and similar submittals are not Contract Documents. The purpose of their submittal is to demonstrate for those portions of the Work for which submittals are required by the Contract Documents the way by which the Contractor proposes to conform to the information given and the design concept expressed in the Contract Documents. Review of submittals by the Architect/Engineer is not conducted for the purpose of determining the accuracy and completeness of other details such as dimensions and quantities, or for substantiating instructions for installation or performance of equipment or systems, or for approval of safety precautions or, unless otherwise specifically stated by the Architect/Engineer, of any construction means, methods, techniques, sequences or procedures, all of which remain the responsibility of the Contractor as required by the Contract Documents. The Architect/Engineer's review of the Contractor's submittals shall not relieve the Contractor of its obligations under the Contract Documents. The Architect/Engineer's approval of a specific item shall not indicate approval of an assembly of which the item is a component. Informational submittals upon which the Architect/Engineer is not expected to take responsive action may be so identified in the Contract Documents. Submittals which are not required by the Contract Documents may be returned by the Architect/Engineer without action.

B.12.3 The Contractor shall review for compliance with the Contract Documents, approve and submit to the Architect/Engineer Shop Drawings, Product Data, Samples and similar submittals required by the Contract Documents with reasonable promptness and in such sequence as to cause no delay in the Work or in the activities of the Owner or of separate contractors. Submittals which are not marked as reviewed for compliance with the Contract Documents and approved by the Contractor may be returned by the Architect/Engineer without action.

B.12.4 By approving and submitting Shop Drawings, Product Data, Samples and similar submittals, the Contractor represents that the Contractor has determined and verified materials, field measurements and field construction criteria related thereto, or will do so, and has checked and coordinated the information contained within such submittals with the requirements of the Work and of the Contract Documents.

B.12.5 The Contractor shall perform no portion of the Work for which the Contract Documents require submittal and review of Shop Drawings, Product Data, Samples or similar submittals until the respective submittal has been approved by the Architect/Engineer.

B.12.6 The Work shall be in accordance with approved submittals except that the Contractor shall not be relieved of responsibility for deviations from requirements of the Contract Documents by the Architect/Engineer's review or approval of Shop Drawings, Product Data, Samples or similar submittals unless the Contractor has specifically informed the Architect/Engineer in writing of such deviation at the time of submittal and (i) the Architect/Engineer has given written approval to the specific deviation as a minor change in the Work, or (ii) a Change Order has been executed by Owner authorizing the deviation. The Contractor shall not be relieved of responsibility for errors or omissions in Shop Drawings, Product Data, Samples or similar submittals by the Architect/Engineer's review or approval thereof.

B.12.7 In the event that Owner elects not to have the obligations and duties described under this Section B.18 performed by the Architect/Engineer, or in the event no Architect/Engineer is employed by Owner on the Project, all obligations and duties assigned to the Architect/Engineer hereunder shall be performed by the Owner.

B.13 SUBSTITUTIONS

The Contractor may make Substitutions only with the written consent of the Owner, after evaluation by the Owner and only in accordance with a Change Order. Substitutions shall be subject to the requirements of the Solicitation Document. By making requests for Substitutions, the Contractor represents that the Contractor has personally investigated the proposed substitute product; represents that the Contractor will provide the same warranty for the Substitution that the Contractor would for the product originally specified unless approved otherwise; certifies that the cost data presented is complete and includes all related costs under the Contract including redesign costs, and waives all claims for additional costs related to the Substitution which subsequently become apparent; and will coordinate the installation of the accepted Substitution, making such changes as may be required for the Work to be completed in all respects.

B.14 USE OF PLANS AND SPECIFICATIONS

Plans, Specifications and related Contract Documents furnished to Contractor by Owner or Owner's Architect/Engineer shall be used solely for the performance of the Work under the Contract. Contractor and its Subcontractors and suppliers are authorized to use and reproduce applicable portions of such documents appropriate to the execution of the Work, but shall not claim any ownership or other interest in them beyond the scope of the Contract, and no such interest shall attach. Unless otherwise indicated, all common law, statutory and other reserved rights, in addition to copyrights, are retained by Owner.

SECTION C
WAGES AND LABOR

C.1 PREVAILING WAGE RATES ON PUBLIC WORKS

Contractor shall comply fully with the provisions of ORS 279C.800 through 279C.870. Pursuant to ORS 279C.830(1)(d), Contractor shall pay workers at not less than the specified minimum hourly rate of wage, and shall include that requirement in all subcontracts. If the Work is subject to both the state prevailing wage rate law and the federal Davis-Bacon Act, Contractor shall pay the higher of the applicable state or federal prevailing rate of wage. Contractor shall provide written notice to all workers of the number of hours per day and days per week such workers may be required to work.

C.2 PAYROLL CERTIFICATION AND FEE REQUIREMENTS

C.2.1 In accordance with ORS 279C.845, the Contractor and every Subcontractor shall submit written certified statements to the Owner on the form prescribed by the Commissioner of the Bureau of Labor and Industries ("BOLI"), certifying the hourly rate of wage paid each worker which the Contractor or the Subcontractor has employed on the Project and further certifying that no worker employed on the Project has been paid less than the prevailing rate of wage or less than the minimum hourly rate of wage specified in the Contract, which certificate and statement shall be verified by the oath of the Contractor or the Subcontractor that the Contractor or Subcontractor has read the certified statement, that the Contractor or Subcontractor knows the contents of the certified statement, and, that to the Contractor's or Subcontractor's best knowledge and belief, the certified statement is true. The certified statements shall set out accurately and completely the payroll records for the prior week, including the name and address of each worker, the worker's correct classification, rate of pay, daily and weekly number of hours worked, deductions made, and actual wages paid. Certified statements for each week during which the Contractor or Subcontractor has employed a worker on the Project shall be submitted once a month, by the fifth (5^{th}) business day of the following month. The Contractor and Subcontractors shall preserve the certified statements for a period of ten (10) years from the date of completion of the Contract.

C.2.2 Pursuant to ORS 279C.845(7), the Owner shall retain 25 percent of any amount earned by the Contractor on the Project until the Contractor has filed the certified statements required by section C.2.1. The Owner shall pay to the Contractor the amount retained under this subsection within 14 days after the Contractor files the required certified statements, regardless of whether a Subcontractor has failed to file certified statements.

C.2.3 Pursuant to ORS 279C.845(8), the Contractor shall retain 25 percent of any amount earned by a first-tier Subcontractor on this Project until the first-tier Subcontractor has filed with the Owner the certified statements required by C.2.1. Before paying any amount retained under this subsection, the Contractor shall verify that the first-tier Subcontractor has filed the certified statement. Within 14 days after the first-tier Subcontractor files the required certified statement the Contractor shall pay the first-tier Subcontractor any amount retained under this subsection.

C.2.4 In accordance with statutory requirements and administrative rules promulgated by the Commissioner of the Bureau of Labor and Industries, the fee required by ORS 279C.825(1) will be paid by Owner to the Commissioner.

C.3 PROMPT PAYMENT AND CONTRACT CONDITIONS

C.3.1 As a condition to Owner's performance hereunder, the Contractor shall:

C.3.1.1 Make payment promptly, as due, to all persons supplying to Contractor labor or materials for the prosecution of the Work provided for in the Contract.

C.3.1.2 Pay all contributions or amounts due the State Industrial Accident Fund or successor program from such Contractor or Subcontractor incurred in the performance of the Contract.

C.3.1.3 Not permit any lien or claim to be filed or prosecuted against the Owner on account of any labor or material furnished. Contractor will not assign any claims that Contractor has against Owner, or assign any sums due by Owner, to Subcontractors, suppliers, or manufacturers, and will not make any agreement or act in any way to give Subcontractors a claim or standing to make a claim against the Owner.

C.3.1.4 Pay to the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.

C.3.2 If Contractor fails, neglects or refuses to make prompt payment of any claim for labor or services furnished to the Contractor of a Subcontractor by any person in connection with the Project as such claim becomes due, the proper officer(s) representing the Owner may pay the claim and charge the amount of the payment against funds due or to become due Contractor under the Contract. Payment of claims in this manner shall not relieve the Contractor or the Contractor's surety from obligation with respect to any unpaid claims.

C.3.3 Contractor shall include in each subcontract for property or services entered into by the Contractor and a first-tier subcontractor, including a material supplier, for the purpose of performing a construction contract, a payment clause that obligates the Contractor to pay the first-tier Subcontractor for satisfactory performance under its subcontract within ten (10) Days out of such amounts as are paid to the Contractor by the Owner under such contract.

C.3.4 If the Contractor or a first-tier subcontractor fails, neglects or refuses to pay a person that provides labor or materials in connection with the Contract within 30 days after receiving payment from the contracting agency or a contractor, the Contractor or first-tier subcontractor owes the person the amount due plus interest charges that begin at the end of the 10-day period within which payment is due under ORS 279C.580 (4) and that end upon final payment, unless payment is subject to a good faith dispute as defined in ORS 279C.580. The rate of interest on the amount due is nine percent per annum. The amount of interest may not be waived.

C.3.5 If the Contractor or a subcontractor fails, neglects or refuses to make payment to a person furnishing labor or materials in connection with the Contract, the person may file a complaint with the Construction Contractors Board, unless payment is subject to a good faith dispute as defined in ORS 279C.580.

C.3.6 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. Contractor shall ensure that each of its Subcontractors complies with these requirements.

C.3.7 In accordance with ORS 279C.570, for all subcontracts that exceed $500,000 that the Contractor withholds retainage, the Contractor shall place amounts deducted as retainage into an interest-bearing escrow account. Interest on the retainage amount accrues from the

date the payment request is approved until the date the retainage is paid to the Subcontractor to which it is due.

C.4 PAYMENT FOR MEDICAL CARE

As a condition to Owner's performance hereunder, Contractor shall promptly, as due, make payment to any person, co-partnership, association or corporation furnishing medical, surgical, and hospital care or other needed care and attention, incident to sickness or injury, to the employees of the Contractor, of all sums of which the Contractor agrees to pay for the services and all moneys and sums that the Contractor collected or deducted from the wages of employees under any law, contract or agreement for the purpose of providing or paying for the services.

C.5 HOURS OF LABOR

As a condition to Owner's performance hereunder, no person shall be employed to perform Work under the Contract for more than ten (10) hours in any one day or forty (40) hours in any one week, except in cases of necessity, emergency or where public policy absolutely requires it. In such instances, Contractor shall pay the employee at least time and a half pay:

(a) For all overtime in excess of eight (8) hours a day or forty (40) hours in any one week when the work week is five consecutive Days, Monday through Friday; or

(b) For all overtime in excess of ten (10) hours a day or forty (40) hours in any one week when the work week is four consecutive Days, Monday through Friday; and

(c) For all Work performed on Saturday and on any legal holiday specified in ORS 279C.540.

This Section C.5 will not apply to Contractor's Work under the Contract to the extent Contractor is currently a party to a collective bargaining agreement with any labor organization.

This Section C.5 shall not excuse Contractor from completion of the Work within the time required under the Contract.

SECTION D
CHANGES IN THE WORK

D.1 CHANGES IN WORK

D.1.1 The terms of the Contract shall not be waived, altered, modified, supplemented or amended in any manner whatsoever, without prior written agreement and then only after any necessary approvals have been obtained. A Change Order is required to modify the Contract, which shall not be effective until its execution by the parties to the Contract and all approvals required by public contracting laws have been obtained.

D.1.2 It is mutually agreed that changes in Plans, quantities, or details of construction may be necessary or desirable during the course of construction. Within the general scope of the Contract, the Owner may at any time, without notice to the sureties and without impairing the Contract, require changes it deems necessary or desirable within the scope of this Project and consistent with this Section D.1. All changes to the Work shall be documented and Change Orders shall be executed under the conditions of the Contract Documents. Such changes may include, but are not limited to:

(a) Modification of specifications and design.
(b) Increases or decreases in quantities.
(c) Increases or decreases to the amount of Work.
(d) Addition or elimination of any Work item.
(e) Change in the duration of the Project.
(f) Acceleration or delay in performance of Work.
(g) Deductive changes.

Deductive changes are those that reduce the scope of the Work, and shall be made by mutual agreement whenever feasible. In cases of suspension or partial termination under Section J, Owner reserves the right to unilaterally impose a deductive change and to self-perform such Work, for which the provisions of Section B.13 (Owner's Right to Do Work) shall then apply. Adjustments in compensation shall be made under Section D.1.3, in which costs for deductive changes shall be based upon a Direct Costs adjustment together with the related percentage markup specified for profit, Overhead and other indirect costs, unless otherwise agreed to by Owner.

D.1.3 The Owner and Contractor agree that adjustments to or deletions from the Work shall be administered and compensated according to the following:

(a) Unit Pricing: Unit pricing may be utilized at the Owner's option when unit prices or solicitation alternates were provided that established the cost for adjustments to Work, and a binding obligation exists under the Contract on the parties covering the terms and conditions of the adjustment to Work.

(b) Fixed Fee: If the Owner elects not to utilize unit pricing, or in the event that unit pricing is not available or appropriate, fixed pricing may be used for adjustments to or deletions from the Work. In fixed pricing, the basis of payments or total price shall be agreed upon in writing between the parties to the Contract, and shall be established before the Work is done whenever feasible. Notwithstanding the foregoing, the mark-ups set forth in Section D.1.3(c) shall be utilized in establishing fixed pricing, and such mark-ups shall not be exceeded. Cost and price data relating to adjustments to or deletions from the Work shall be supplied by Contractor to Owner upon request, but Owner shall be under no obligation to make such requests.

(c) Time and Material: In the event that unit pricing and fixed pricing are not utilized, then adjustments to or deletions from the Work shall be performed on a cost reimbursement basis for Direct Costs. Such Work shall be compensated on the basis of the actual, reasonable and allowable cost of labor, equipment, and material furnished on the Work performed. The Contractor or Subcontractor who performs the Work shall be allowed to add up to ten percent (10%) markup to the Direct Costs as full compensation for profit, Overhead and other indirect costs for Work performed with the Contractor's or Subcontractor's own agents

Each ascending tier Subcontractor or the Contractor that did not perform the Work, will be allowed to add up to five percent (5%) supplemental markup on the Direct Costs of the Work (but not the above allowable markups) covered by a Change Order. No additional markup shall be permitted for any third tier or greater descending Subcontractor.

Example: $20,000 of Direct Costs Work performed by a 2nd Tier Subcontractor

	Markup	Allowed Total Fee Plus Markup
General Contractor	5%	$1,000.00
1st Tier Sub Contractor	5%	$1,000.00
2nd Tier Sub Contractor	10%	$22,000.00

(d) Payments made to the Contractor shall be complete compensation for Overhead, profit, and all costs that were incurred by the Contractor or by other agents furnished by the Contractor, including Subcontractors, for adjustments to or deletions from the Work pursuant to a Change Order. Owner may establish a maximum cost for additional Work under this Section D.1.3, which shall not be exceeded for reimbursement without additional written

authorization from Owner in the form of a Change Order. Contractor shall not be required to complete such additional Work without additional authorization.

D.1.4 Any necessary adjustment of Contract Time that may be required as a result of adjustments to or deletions from the Work must be agreed upon by the parties before the start of the revised Work unless Owner authorizes Contractor to start the revised Work before agreement on Contract Time adjustment.

Contractor shall submit any request for additional compensation (and additional Contract Time if Contractor was authorized to start Work before an adjustment of Contract Time was approved) as soon as possible but no later than thirty (30) Days after receipt of Owner's request for additional Work . If Contractor's request for additional compensation or adjustment of Contract Time is not made within the thirty (30) Day time limit, Contractor's requests pertaining to that additional Work shall be barred. The thirty (30) Day time limit for making requests shall not be extended for any reason, including without limitation Contractor's claimed inability to determine the amount of additional compensation or adjustment of Contract Time, unless an extension is granted in writing by Owner. If the Owner denies Contractor's request for additional compensation or adjustment of Contract Time, Contractor may proceed to file a Claim under Section D.3, Claims Review Process. No other reimbursement, compensation, or payment will be made, except as provided in Section D.1.5 for impact claims.

D.1.5 If any adjustment to Work under Section D.1.3 causes an increase or decrease in the Contractor's cost of, or the Contract Time required for the performance of any other part of the Work under the Contract, Contractor shall submit a written request to the Owner, setting forth the nature and specific extent of the request, including all time and cost impacts against the Contract as soon as possible, but no later than thirty (30) Days after receipt of Owner's request for adjustments to or deletions from the Work by Contractor.

The thirty (30) Day time limit applies to claims of Subcontractors, suppliers, or manufacturers who may be affected by Owner's request for adjustments to or deletions from the Work and who request additional compensation or an extension of Contract Time to perform; Contractor has responsibility for contacting its Subcontractors, suppliers, or manufacturers within the thirty (30) Day time limit, and including their requests with Contractor's requests. If the request involves Work to be completed by Subcontractors, or materials to be furnished by suppliers or manufacturers, such requests shall be submitted to the Contractor in writing with full analysis and justification for the adjustments to compensation and Contract Time requested. The Contractor shall analyze and evaluate the merits of the requests submitted by Subcontractors, suppliers, and manufacturers to Contractor prior to including those requests and Contractor's analysis and evaluation of those requests with Contractor's requests for adjustments to compensation or Contract Time that Contractor submits to the Owner. Failure of Subcontractors, suppliers, manufacturers or others to submit their requests to Contractor for inclusion with Contractor's requests submitted to Owner within the time period and by the means described in this section shall constitute a waiver of these Subcontractor claims. The Owner will not consider direct requests or claims from Subcontractors, suppliers, manufacturers or others not a party to the Contract. The consideration of such requests and claims under this section does not give any Person, not a party to the Contract the right to bring a claim against Owner, whether in this claims process, in litigation, or in any dispute resolution process.

If the Owner denies the Contractor's request for adjustment to compensation or Contract Time, the Contractor may proceed to file a Claim under Section D.3, Claims Review Process.

D.1.6 No request or Claim by the Contractor for additional costs or an adjustment of Contract Time shall be allowed if made after receipt of final payment application under the Contract. Final payment application must be made by Contractor within the time required under Section E.6.4.

D.1.7 It is understood that changes in the Work are inherent in construction of this type. The number of changes, the scope of those changes, and the effect they have on the progress of the original Work cannot be defined at this time. The Contractor agrees that it will work in good faith with Owner to undertake changes, when agreed upon by execution of a Change Order. Each change will be evaluated for extension of Contract Time and increase or decrease in compensation based on its own merit.

D.2 DELAYS

D.2.1 Contractor shall not be entitled to additional compensation or additional Contract Time for Avoidable Delays.

D.2.2 In the event of Unavoidable Delays, Contractor may be entitled to the following:

(a) Contractor may be entitled to additional compensation or additional Contract Time, or both, for Unavoidable Delays described in Section D.2.1.2 (a) and (b).

(b) Contractor may be entitled to additional Contract Time for Unavoidable Delays described in Section D.2.1.2(c) and (d).

In the event of any requests for additional compensation or additional Contract Time, or both, as applicable, arising under this Section D.2.2 for Unavoidable Delays, other than requests for additional compensation or additional Contract Time for differing Project Site conditions for which a review process is established under Section A.4.5, Contractor shall submit a written notification of the delay to the Owner within two (2) Days of the occurrence of the cause of the delay. This written notification shall state the cause of the potential delay, the Project components impacted by the delay, and the anticipated additional Contract Time extension or the additional compensation, or both, as applicable, resulting from the delay. Within seven (7) Days after the cause of the delay has been mitigated, or in no case more than thirty (30) Days after the initial written notification, the Contractor shall submit to the Owner, a complete and detailed request for additional compensation or additional Contract Time, or both, as applicable, resulting from the delay. If the Owner denies Contractor's request for additional compensation or adjustment of Contract Time, the Contractor may proceed to file a Claim under Section D.3, Claims Review Process.

If Contractor does not timely submit the notices required under this Section D.2, Contractor's Claim shall be barred.

D.3 CLAIMS REVIEW PROCESS

D.3.1 All Contractor Claims shall be referred to the Owner for review. Contractor's Claims, including Claims for adjustments to compensation or Contract Time, shall be submitted in writing by Contractor to the Owner within five (5) Days after a denial of Contractor's initial request for an adjustment of Contract terms, payment of money, extension of Contract Time or other relief, provided that such initial request has been submitted in accordance with the requirements and within the time limits established in these County General Conditions. Within thirty (30) Days after the initial Claim, Owner shall receive from Contractor a complete and detailed description of the Claim (the "Detailed Notice") that includes all information required by Section D.3.2. Unless the Claim is made in accordance with these time requirements, it shall be barred.

D.3.2 The Detailed Notice of the Claim shall be submitted in writing by Contractor and shall include all information, records and documentation necessary for the Owner to properly and completely evaluate the claim, including, but not limited to a detailed, factual statement of the basis of the Claim, pertinent dates, Contract provisions which support or allow the Claim, reference to or copies of any documents which support the Claim, the dollar value of the Claim, and the Contract Time adjustment requested for the Claim. If the Claim involves Work to be completed by Subcontractors, the Contractor will analyze and evaluate the merits of the Subcontractor claim prior to forwarding it and that analysis and evaluation to the Owner. The Owner will not consider direct claims from Subcontractors, suppliers, manufacturers, or others not a party to the Contract. Contractor agrees that it will make no agreement, covenant, or assignment, nor will it commit any other act that will permit or assist any Subcontractor, supplier, manufacturer, or other to directly or indirectly make a claim against Owner.

D.3.3 The Owner, through the Architect/Engineer (or other employee or agent assigned by the Owner) will review all Claims and take one or more of the following preliminary actions within ten (10) Days of receipt of the Detailed Notice of a Claim: (1) request additional supporting information from the Contractor; (2) inform the Contractor and Owner in writing of the time required for adequate review and response; (3) reject the Claim in whole or in part and identify the reasons for rejection; (4) recommend approval of all or part of the Claim; (5) arrange a meeting with the Contractor for formal review of the Claim; or (6) propose an alternate resolution.

D.3.4 Once the Engineer or Project Manager determines the Owner is in receipt of a properly submitted claim, the Engineer or Project Manager may arrange a meeting, as agreed by the parties, with the Contractor in order to present the claim for formal review and discussion. A person authorized by the Contractor to execute Change Orders on behalf of the Contractor must be present and attend all claim meetings.

D.3.5 The Owner's decision, through the Architect/Engineer (or other employee or agent assigned by the Owner), shall be final and binding on the Contractor unless appealed by written notice to the Owner within fifteen (15) Days of receipt of the decision. The Contractor must present written documentation supporting the Claim within fifteen (15) Days of the notice of appeal. After receiving the appeal documentation, the Owner, through the appropriate department director, shall review the materials and render a decision within thirty (30) Days after receiving the appeal documents.

D.3.6 If, at any step in the claim decision or review process, the Contractor fails to promptly submit requested information or documentation that the Owner deems necessary to analyze the claim, the Contractor is deemed to have waived its right to further review, and the Claim will not be considered properly filed and preserved.

D.3.7 Both parties agree to exercise their best efforts in good faith to resolve all disputes within sixty (60) Days of the issuance of the appeal in Section D. 3.4 above. If the parties are unable to resolve their issues through mediation or otherwise, either party may seek redress through all available remedies in equity or in law.

D.3.8 Unless otherwise directed by Owner, Contractor shall proceed with the Work while any Claim, or mediation or litigation arising from a Claim, is pending. Regardless of the review period or the final decision of the Owner, the Contractor shall continue to diligently pursue the Work as identified in the Contract Documents. In no case is the Contractor justified or allowed to cease or delay Work, in whole or in part, without a written stop work order from the Owner.

SECTION E
PAYMENTS

E.1 SCHEDULE OF VALUES

The Contractor shall submit, by or before the pre-construction conference (as described in Section H.1.3), a schedule of values ("Schedule of Values") for the Contract Work. This schedule shall provide a breakdown of values for the Contract Work and will be the basis for progress payments. The breakdown shall demonstrate reasonable, identifiable, and measurable components of the Work. Unless objected to by the Owner, this schedule shall be used as the basis for reviewing Contractor's applications for payment. If objected to by Owner, Contractor shall revise the schedule of values and resubmit the same for approval of Owner.

E.2 APPLICATIONS FOR PAYMENT

E.2.1 Owner shall make progress payments on the Contract monthly as Work progresses, in accordance with the requirements of this Section E.2 and ORS 279C.570. Applications for payment shall be based upon estimates of Work completed and the Schedule of Values. As a condition precedent to Owner's obligation to pay, all applications for payment shall be approved by the Owner. A progress payment shall not be considered acceptance or approval of any Work or waiver of any defects therein. Owner shall pay to Contractor interest in accordance with ORS 279C.570 for overdue invoices, not including retainage, due the Contractor. Overdue invoices will be those that have not been paid within the earlier of:

(a) Thirty (30) days after receipt of the invoice; or

(b) Fifteen (15) days after the payment is approved by the County.

Notwithstanding the foregoing, in instances when an application for payment is filled out incorrectly, or when there is any defect or impropriety in any submitted application or when there is a good faith dispute, Owner shall so notify the Contractor within fifteen (15) Days stating the reason or reasons the application for payment is defective or improper or the reasons for the dispute. A defective or improper application for payment, if corrected by the Contractor within seven (7) Days of being notified by the Owner, shall not cause a payment to be made later than specified in this section unless interest is also paid. Payment of interest will be postponed when payment on the principal is delayed because of disagreement between the Owner and the Contractor.

Owner reserves the right, instead of requiring the Contractor to correct or resubmit a defective or improper application for payment, to reject the defective or improper portion of the application for payment and pay the remainder of the application for such amounts which are correct and proper.

Owner, upon written notice to the Contractor, may elect to make payments to the Contractor only by means of Electronic Funds Transfers ("EFT") through Automated Clearing House ("ACH") payments. If Owner makes this election, the Contractor shall arrange for receipt of the EFT/ACH payments.

E.2.2 Contractor shall submit to the Owner an application for each payment and, if required, receipts or other vouchers showing payments for materials and labor including payments to Subcontractors. Contractor shall include in its application for payment a schedule of the percentages of the various parts of the Work completed, based on the Schedule of Values which shall aggregate to the payment application total, and shall include, on the face of each copy thereof, a certificate in substantially the following form:

"I, the undersigned, hereby certify that the above bill is true and correct, and the payment therefore, has not been received.

Signed: _____
Dated: _____"

E.2.3 Generally, applications for payment will be accepted only for materials that have been installed. Under special conditions, applications for payment for stored materials will be accepted at Owner's sole discretion. Such a payment, if made, will be subject to the following conditions:

(a) The request for stored material shall be submitted at least thirty (30) Days in advance of the application for payment on which it appears. Applications for payment shall be entertained for major equipment, components or expenditures only.

(b) The Contractor shall submit applications for payment showing the quantity and cost of the material stored.

(c) The material shall be stored in a bonded warehouse and Owner shall be granted the right to access the material for the purpose of removal or inspection at any time during the Contract Period.

(d) The Contractor shall name the Owner as co-insured on the insurance policy covering the full value of the property while in the care and custody of the Contractor until it is installed. A certificate noting this coverage shall be issued to the Owner.

(e) Payments shall be made for materials and equipment only. The submitted amount in the application for payment shall be reduced by the cost of transportation from the storage site to the Project Site and for the cost of an inspector to verify delivery and condition of the goods at the storage site. The cost of storage and inspection shall be borne solely by the Contractor.

(f) Within sixty (60) Days of the application for payment, the Contractor shall submit evidence of payment covering the material and/or equipment stored and of payment for the storage site.

(g) Payment for stored materials and/or equipment shall in no way indicate acceptance of the materials and/or equipment or waive any rights under the Contract for the rejection of the Work or materials and/or equipment not in conformance with the Contract Documents.

(h) All required documentation shall be submitted with the respective application for payment.

E.2.4 The Owner reserves the right to withhold all or part of a payment, or may nullify in whole or part any payment previously made, to such extent as may be necessary in the Owner's opinion to protect the Owner from loss because of:

(a) Work that is defective and not remedied, or that has been demonstrated or identified as failing to conform with Applicable Laws or the Contract Documents;

(b) third party claims filed or evidence reasonably indicating that such claims will likely be filed unless security acceptable to the Owner is provided by the Contractor;

(c) failure of the Contractor to make payments properly to Subcontractors or for labor, materials or equipment (in which case Owner may issue checks made payable jointly to Contractor and such unpaid persons under this provision, or directly to Subcontractors and suppliers at any level under Section C.3.2);

(d) reasonable evidence that the Work cannot be completed for the unpaid balance of the Contract Price;

(e) damage to the Work, Owner or Owner's agent;

(f) reasonable evidence that the Work will not be completed within the Contract Time required by the Contract, and that the unpaid balance would not be adequate to cover actual or liquidated damages for the anticipated delay;

(g) failure to carry out the Work in accordance with the Contract Documents; or

(h) assessment of liquidated damages, when withholding is made for offset purposes.

E.2.5 Subject to the provisions of the Contract Documents, the amount of each progress payment shall be computed as follows:

(a) Take that portion of the Contract Price properly allocable to completed Work as determined by multiplying the percentage completion of each portion of the Work by the share of the total Contract Price allocated to that portion of the Work in the Schedule of Values, less retainage as provided in Section E.5. Pending final determination of cost to the Owner of changes in the Work, no amounts for changes in the Work can be included in applications for payment until the Contract Price has been adjusted by a Change Order;

(b) Add that portion of the Contract Price properly allocable to materials and equipment delivered and suitably stored at the Project Site for subsequent incorporation in the completed construction (or, if approved in advance by the Owner pursuant to Section E.2.3, suitably stored off the Project Site at a location agreed upon in writing), less retainage as provided in Section E.5;

(c) Subtract the aggregate of previous payments made by the Owner; and

(d) Subtract any amounts for which the Owner has withheld or nullified payment as provided in the Contract Documents.

E.2.6 Contractor's applications for payment shall not include requests for payment for portions of the Work for which the Contractor does not intend to pay to a Subcontractor or material supplier.

E.2.7 The Contractor warrants to Owner that title to all Work covered by an application for payment will pass to the Owner no later than the time of payment. The Contractor further warrants that upon submittal of an application for payment all Work for which payments are received from the Owner shall be free and clear of liens, claims, security interests or encumbrances in favor of the Contractor, Subcontractors, material suppliers, or other persons or entities making a claim by reason of having provided financing, labor, materials and equipment relating to the Work.

E.2.8 If Contractor disputes any determination by Owner with regard to any application for payment, Contractor nevertheless shall continue to expeditiously perform the Work. No payment made hereunder shall be or be construed to be final acceptance or approval of that portion of the Work to which such partial payment relates or shall relieve Contractor of any of its obligations hereunder.

E.3 PAYROLL CERTIFICATION REQUIREMENT

Owner's receipt of payroll certification pursuant to Section C.2 of the Contract shall be a condition precedent to Owner's obligation to pay any progress payments or final payment otherwise due.

E.4 DUAL PAYMENT SOURCES

Contractor shall not be compensated for Work performed under the Contract from any state agency other than the agency that is a party to the Contract.

E.5 RETAINAGE

E.5.1 Retainage shall be withheld and released in accordance with the requirements set forth in Local Contract Review Board Rules or the applicable County standard.

E.5.1.1 Owner may reserve as retainage from any progress payment an amount not to exceed five percent of the payment. As Work progresses, Owner may reduce the amount of retainage on or may eliminate retainage on any remaining monthly Contract payments after fifty (50) percent of the Work under the Contract is completed if, in the Owner's discretion, such Work is progressing satisfactorily. Elimination or reduction of retainage shall be allowed only upon written application by the Contractor, which application shall include written approval of Contractor's surety; except that when the Work is ninety-seven and a half percent (97.5%) completed in Owner's estimation, the Owner may, at its discretion and without application by the Contractor, reduce the retained amount to hundred (100) percent of the value of the Work remaining to be done. Upon receipt of written application by the Contractor, Owner shall respond in writing within a reasonable time.

E.5.1.2 If retainage is withheld, unless the Contractor requests and the Owner accepts a form of retainage described in options (a) or (b) below, the Owner (except as otherwise provided below for a contract of $500,000 or less), will deposit the retainage in an interest-bearing escrow account as required by ORS 279C.570(2). The Contractor shall execute such documentation and instructions respecting the interest-bearing escrow account as the Owner may require to protect its interests, including but not limited to a provision that no funds may be paid from the account to anyone without the Owner's advance written authorization. For a Contract over $500,000, if the Contractor requests that the Owner deposit the retainage in an interest-bearing account under ORS 279C.560(5), the Owner will use an interest-bearing escrow account as stated above. For a Contract of $500,000 or less, if the Contractor requests that the Owner deposit the retainage in an interest-bearing account under ORS 279C.560(5), the Owner will use an interest-bearing account (in a bank, savings bank, trust company or savings association) as provided under ORS 279C.450(5).

In accordance with the provisions of ORS 279C.560, Local Contract Review Board Rules, or the applicable County standard, unless the Owner finds in writing that accepting bonds, securities or other instruments described in option (a) below or a security bond described in option (b) below poses an extraordinary risk that is not typically associated with the bond, security or instrument, the Owner will approve the Contractor's written request:

a. to be paid amounts which would otherwise have been retained from progress payments where Contractor has deposited acceptable bonds, securities or other instruments of equal value with Owner or in a custodial account or other mutually-agreed account satisfactory to Owner, with an approved bank or trust company to be held in lieu of the cash retainage for the benefit of Owner. Interest or earnings on the bonds, securities or other instruments shall accrue to the Contractor. The Contractor shall execute and provide such documentation and instructions respecting the bonds, securities and other instruments as the Owner may require to protect its interests. To be permissible, the bonds, securities and other instruments must be of a character approved by Owner; or

b. that the Contractor be allowed, with the approval of the Owner, Owner allow Contractor to deposit a surety bond for the benefit of Owner, in a form acceptable to Owner, in lieu of all or a portion of funds retained, or to be retained. Such bond and any proceeds therefrom shall be made subject to all claims and liens in the manner and priority as set forth for retainage under ORS 279C.550 to ORS 279C.625.

When the Owner has accepted the Contractor's election of option (a) or (b), Owner may recover from Contractor any additional costs incurred through such election by reducing Contractor's final payment. Where the Owner has agreed to Contractor's request for option (b), Contractor shall accept like bonds from Subcontractors and suppliers on the Project from which Contractor has required retainages.

E. 5.1.3 The retainage held by Owner shall be included in and paid to the Contractor as part of the final payment of the Contract Price. The Owner shall pay to Contractor interest at the rate of two thirds of one percent per month on the final payment due Contractor, interest to commence forty-five (45) Days after the date which Owner receives Contractor's final approved application for payment and Work under the Contract has been completed and accepted and to run until the date when final payment is tendered to Contractor. The Contractor shall notify Owner in writing when the Contractor considers the Work complete and deliver to Owner its final application for payment and Owner shall, within fifteen (15) Days after receiving the written notice and the application for payment, either accept the Work or notify the Contractor of Work yet to be performed on the Contract. If Owner does not within the time allowed notify the Contractor of Work yet to be performed to fulfill contractual obligations, the interest provided by this subsection shall commence to run forty-five (45) Days after the end of the fifteen (15) Day period.

E.5.1.4 Owner will reduce the amount of the retainage if the Contractor notifies the Owner that the Contractor has deposited in an escrow account with a bank or trust company, in a manner authorized by the Owner, bonds and securities of equal value of a kind approved by the Owner and such bonds and securities have in fact been deposited.

E.5.1.5 Contractor agrees that if Contractor elects to reserve a retainage from any progress payment due to any Subcontractor or supplier, such retainage shall not exceed five percent of the payment, and such retainage withheld from Subcontractors and suppliers shall be subject to the same terms and conditions stated in Subsection E.5 as apply to Owner's retainage from any progress payment due to Contractor.

E.5.1.6 The Contractor shall comply with all applicable legal requirements for withholding and releasing retainage and for prompt payments, including but not limited to those in ORS Chapters 279C and 701, and 49 CFR 26.29.

E.6 FINAL PAYMENT

E.6.1 Upon completion of all the Work under the Contract, the Contractor shall notify the Owner, in writing, that Contractor has completed Contractor's obligations under the Contract and shall prepare its application requesting final payment. The amount of final payment will be the difference between the total amount due the Contractor pursuant to the Contract Documents and the sum of all payments previously made. Upon receipt of such notice and application for payment, the Owner will inspect the Work, and, if acceptable, submit to Contractor a recommendation as to acceptance of the completed Work and the final estimate of the amount due the Contractor. If the Work is not acceptable, Owner will notify Contractor within fifteen (15) Days of Contractor's request for final payment. Upon approval of this final application for payment by the Owner and compliance by the Contractor with

provisions in Section K, and Contractor's satisfaction of other provisions of the Contract Documents as may be applicable, the Owner shall pay to the Contractor all monies due under the provisions of these Contract Documents.

E.6.2 Neither final payment nor any remaining retained percentage shall become due until the Contractor submits to the Owner (1) a certificate evidencing that insurance required by the Contract Documents to remain in force after final payment is currently in effect and will not be canceled or allowed to expire until at least thirty (30) Days' prior written notice has been given to the Owner, (2) a written statement that the Contractor knows of no substantial reason that the insurance will not be renewable to cover the period required by the Contract Documents, (3) consent of surety, if any, to final payment and (4), if required by the Owner, other data establishing payment or satisfaction of obligations, such as receipts, releases and waivers of liens, claims, security interests or encumbrances arising out of the Contract, to the extent and in such form as may be designated by the Owner. If a Subcontractor refuses to furnish a release or waiver required by the Owner, the Contractor may furnish a bond satisfactory to the Owner to indemnify the Owner against such lien. If such lien remains unsatisfied after payments are made, the Contractor shall refund to the Owner all money that the Owner may be compelled to pay in discharging such lien.

E.6.3 Acceptance of final payment by the Contractor, a Subcontractor or material supplier shall constitute a waiver of claims by that payee except those previously made in writing and identified by that payee as unsettled at the time of final application for payment.

E.6.4 Contractor agrees to submit its final payment application within ninety (90) Days after Substantial Completion, unless written extension is granted by Owner. Contractor shall not delay final payment application for any reason, including without limitation nonpayment of Subcontractors, suppliers, manufacturers or others not a party to the Contract, or lack of resolution of a dispute with Owner or any other person of matters arising out of or relating to the Contract. If Contractor fails to submit its final payment application within ninety (90) Days after Substantial Completion, and Contractor has not obtained written extension by Owner, all requests or Claims for additional costs or an extension of Contract Time shall be barred.

SECTION F
PROJECT SITE CONDITIONS

F.1 USE OF PREMISES

Contractor shall confine equipment, storage of materials and operation of Work to the limits indicated by Contract Documents, Applicable Laws, permits or directions of the Owner. Contractor shall follow the Owner's instructions regarding use of premises, if any.

F.2 PROTECTION OF WORKERS, PROPERTY AND THE PUBLIC

F.2.1 Contractor shall maintain continuous and adequate protection of all of the Work from damage and shall protect the Owner, workers and property from injury or loss arising in connection with the Contract. Contractor shall remedy acceptably to the Owner any damage, injury, or loss, except such as may be directly due to errors in the Contract Documents or caused by authorized representatives or personnel of the Owner. Contractor shall adequately protect adjacent property as provided by law and the Contract Documents.

F.2.2 Contractor shall take all necessary precautions for the safety of all personnel on the Project Site or otherwise engaged in the undertaking of the Work and shall comply with the Contract Documents, best practices and all applicable provisions of federal, state and municipal safety laws and building codes to prevent accidents or injury to persons on, about or adjacent to the premises where the Work is being performed. Contractor shall erect and properly maintain at all times, as required by the conditions and progress of the Work, all necessary safeguards for protection of workers and the public against any hazards created by construction. Contractor shall designate a responsible employee or associate on the Project Site, whose duty shall be the prevention of accidents. The name and position of the person designated shall be reported to the Owner. The Owner has no responsibility for Project Site safety. Project Site safety shall be the responsibility of the Contractor.

F.2.3 Contractor shall not enter upon private property without first obtaining permission from the property owner or its duly authorized representative. Contractor shall be responsible for the preservation of all public and private property along and adjacent to the Work contemplated under the Contract and shall use every precaution necessary to prevent damage thereto. In the event the Contractor damages any property, the Contractor shall at once notify the property owner and make, or arrange to make, full restitution. Contractor shall, immediately and in writing, report to the Owner, all pertinent facts relating to such property damage and the ultimate disposition of the claim for damage.

F.2.4 Contractor shall be responsible for protection of adjacent work areas including impacts brought about by activities, equipment, labor, utilities, vehicles and materials on the Project Site.

F.2.5 Contractor shall at all times direct its activities in such a manner as to minimize adverse effects on the environment. Handling of all materials shall be conducted so no release will occur that may pollute or become hazardous.

F.2.6 In an emergency affecting the safety of life or limb or of the Work or of adjoining property, the Contractor, without special instruction or authorization from the Owner, shall act reasonably to prevent threatened loss or injury, and shall so act, without appeal, if instructed by the Owner. Any compensation claimed by the Contractor on account of emergency work shall be determined in accordance with section D.

F.2.7 Contractor shall comply with all Owner safety rules and regulations, if applicable. Prior to commencement of any Work, Contractor and Subcontractors shall be required to complete an Owner Contractor Safety Orientation and submit all Owner required safety plans.

F.2.8 Contractor shall demonstrate that an employee drug testing program is in place.

F.3 CUTTING AND PATCHING

F.3.1 If applicable, Contractor shall be responsible for coordinating all cutting, fitting, or patching of the Work to make its several parts come together properly and fit to receive or be received by work of other contractors or Subcontractors shown upon, or reasonably implied by, the Contract Documents.

F.3.2 If applicable, Contractor shall be responsible for restoring all cut, fitted, or patched surfaces to an original condition; provided, however, that if a different condition is specified in the Contract Documents, then Contractor shall be responsible for restoring such surfaces to the condition specified in the Contract Documents.

F.4 CLEANING UP

From time to time as may be prudent or ordered by the Owner and, in any event, immediately after completion of the Work, the Contractor shall, at its own expense, clean up and remove all refuse and unused materials of any kind resulting from the Work. If Contractor fails to do so within twenty-four (24) hours after notification by the Owner the work may be

done by others and the cost charged to the Contractor and deducted from payment due the Contractor.

F.5 ENVIRONMENTAL CONTAMINATION

F.5.1. Contractor shall be held responsible for and shall indemnify, defend (with counsel of Owner's choice), and hold harmless Owner from and against any costs, expenses, damages, claims, and causes of action, or any of them, resulting from all spills, releases, discharges, leaks and disposal of environmental pollution, including storage, transportation, and handling during the performance of the Work or Contractor's obligations under the Contract which occur as a result of, or are contributed by, the negligence or actions of Contractor or its personnel, agents, or Subcontractors or any failure to perform in accordance with the Contract Documents (except to the extent otherwise void under ORS 30.140). Nothing in this section F.5.1 shall limit Contractor's responsibility for obtaining insurance coverages required under Section G.3 of the Contract, and Contractor shall take no action that would void or impair such coverages.

F.5.1.1 Contractor agrees to promptly dispose of such spills, releases, discharge or leaks to the satisfaction of Owner and regulatory agencies having jurisdiction in a manner that complies with Applicable Laws. Cleanup shall be at no cost to the Owner and shall be performed by properly qualified and, if applicable, licensed personnel.

F.5.1.2 Unless otherwise approved in the Solicitation Document, Contractor shall obtain the Owner's written consent prior to bringing onto the Project Site any (i) environmental pollutants or (ii) hazardous substances or materials, as the same or reasonably similar terms are used in any Applicable Laws. In any event, Contractor shall provide prior written notice to Owner when hazardous materials are brought on to the Project Site. The Contractor, at all times, shall:

(a) properly handle, use and dispose of all environmental pollutants and hazardous substances or materials on the Project Site, in accordance with all Applicable Laws;

(b) be responsible for any and all spills, releases, discharges, or leaks of (or from) environmental pollutants or hazardous substances or materials which Contractor has brought onto the Project Site; and

(c) promptly clean up and remediate, without cost to the Owner, such spills, releases, discharges, or leaks to the Owner's satisfaction and in compliance with all Applicable Laws.

F.5.2 Contractor shall report all reportable quantity releases, as such releases are defined in Applicable Laws. Upon discovery, regardless of quantity, Contractor must verbally report all releases to the Owner in a prompt manner. A written follow-up report shall be submitted to Owner within 48 hours of the telephonic report. Such written report shall contain, as a minimum:

(a) Description of items released (identity, quantity, manifest numbers, and any and all other documentation required by law).

(b) Whether amount of items released is EPA/DEQ reportable, and, if so, when reported.

(c) Exact time and location of release, including a description of the area involved.

(d) Containment procedures initiated.

(e) Summary of communications about the release between Contractor and State, local or federal officials other than Owner. Any communication to the press will be done by Owner and Contractor will defer to Owner.

(f) Description of cleanup procedures employed or to be employed at the Project Site, including disposal location of spill residue.

(g) Personal injuries, if any, resulting from, or aggravated by, the release.

F.6 ENVIRONMENTAL CLEAN-UP

F.6.1 Unless disposition of environmental pollution is specifically a part of the Contract, or was caused by the Contractor (reference F.5 Environmental Contamination), Contractor shall immediately notify Owner of any hazardous substance(s) which Contractor discovers or encounters during performance of the Work required by the Contract. "Hazardous substance(s)" means any hazardous, toxic and radioactive materials and those substances defined as "hazardous substances," "hazardous materials," "hazardous wastes," "toxic substances," or other similar designations in any federal, state, or local law, regulation, or ordinance, including without limitation asbestos, polychlorinated biphenyl ("PCB"), or petroleum, and any substances, materials or wastes regulated by 40 CFR, Part 261 and defined as hazardous in 40 CFR S 261.3. In addition to notifying Owner of any hazardous substance(s) discovered or encountered, Contractor shall immediately cease working in any particular area of the Project where a hazardous substance(s) has been discovered or encountered if continued work in such area would present a risk or danger to the health or wellbeing of Contractor's or any Subcontractor's work force, property or the environment.

F.6.2 Upon being notified by Contractor of the presence of hazardous substance(s) on the Project Site, not brought on to the Project Site by Contactor, Owner shall arrange for the proper disposition of such hazardous substance(s).

F.7 DEMOLITION

F.7.1 For demolition tasks, if any, the Contractor shall salvage or recycle construction and demolition debris, if feasible and cost-effective.

SECTION G
INDEMNITY, BONDING, AND INSURANCE

G.1 RESPONSIBILITY FOR DAMAGES / INDEMNITY

G.1.1 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.

G.1.2 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 G.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 G.1.2.

G.1.3 In claims against any person or entity indemnified under Section G.1.2 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 G.1.2 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.

G.2 PERFORMANCE AND PAYMENT SECURITY; PUBLIC WORKS BOND

G.2.1 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.

G.2.2 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.

G.2.3 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.

G.3 INSURANCE

G.3.1 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.

G.3.2 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.

G.3.3 Builder's Risk Insurance:

G.3.3.1 Builder's Risk: 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.

G.3.3.2 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.

G.3.3.3 Such insurance shall be maintained until Owner has occupied the facility.

G.3.3.4 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.

G.3.4 General Liability Insurance:

G.3.4.1 Commercial General Liability: Upon execution of a Contract, Contractor shall obtain, and keep in effect at Contractor's expense for the term of the Contract, Commercial General Liability Insurance ("CGL") covering bodily injury and property damage in the amount of not less than $1,000,000 per claim and $2,000,000 per occurrence in a form satisfactory to Owner. This insurance shall include personal injury liability, products and completed operations, and contractual liability coverage for the indemnities provided under the Contract (to the extent contractual liability coverage for the indemnity is available in the marketplace), and shall be issued on an occurrence basis written on ISO Form GC 00 01 (12 04 or later) or an equivalent form approved in advance by Owner. The CGL shall provide separation of insured language. The policy or policies obtained by Contractor for purposes of fulfilling the requirements of this section shall be primary insurance with respect to the Owner. Any insurance or self-insurance maintained by the County shall be excess and shall not contribute to it.

G.3.4.2 Automobile Liability: Contractor shall obtain, at Contractor's expense, and keep in effect during the term of the Contract, Automobile Liability Insurance covering owned, and/or hired vehicles, as applicable. The coverage may be written in combination with the Commercial General Liability Insurance. Contractor shall provide proof of insurance of not less than $1,000,000 per claim and $2,000,000 per occurrence. Contractor

and its Subcontractors shall be responsible for ensuring that all non-owned vehicles maintain adequate Automobile Liability insurance while on Project Site.

G.3.4.3 Owner may adjust the insurance amounts required in Section G.3.4.1 and G.3.4.2 based upon institution specific risk assessments through the issuance of Supplemental General Conditions and a Contract.

G.3.4.4 To the extent that the Contract Documents require the Contractor to provide professional design services, design-build, or certifications related to systems, materials, or equipment, the Contractor shall (1) purchase and maintain professional liability/errors-and-omissions insurance with limits of not less than $1,000,000 for each claim and $2,000,000 general annual aggregate and (2) cause those Subcontractors (of any tier) who are providing professional design services including any design-build services to procure and maintain professional liability/errors-and-omissions insurance with limits of not less than $1,000,000 for each claim and $2,000,000 general annual aggregate. This policy shall be for the protection of the Owner, its elected officials, officers, agents 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 the Contract. The Owner, at its option, may require a complete copy of the above policy.

G.3.4.5 "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).

G.3.4.6 Umbrella Liability (if required by Owner through issuance of Supplemental General Conditions): Contractor shall obtain, at Contractor's expense, and keep in effect during the term of the Contract, Umbrella liability Insurance over and above the general liability, automobile liability and workers' compensation coverage if required by Owner in specified limits at time of requirement.

G.3.4.7 Pollution Liability may be required by Owner through issuance of Supplemental General Conditions.

G.3.5 Additional Insured: The general liability insurance coverage, automobile liability, umbrella, and pollution liability if required, shall include the Owner as additional insureds but only with respect to the Contractor's activities to be performed under the Contract. The additional-insured endorsement for CGL insurance must be written on ISO Form CG 20 10 (10 01) and CG 20 37 (10 01), or their equivalent, but shall not use either of the following forms: CG 20 10 (10 93) or CG 20 10 (03 94). Proof of insurance must include a copy of the endorsement showing "Clackamas County, its elected officials, agents, officers, and employees" as scheduled insureds.

If Contractor cannot obtain an insurer to name the Owner as additional insureds, Contractor shall obtain at Contractor's expense, and keep in effect during the term of the Contract, Owners and Contractors Protective Liability Insurance, naming the Owner as additional insureds with not less than a $2,000,000 limit per occurrence. This policy must be kept in effect for 36 months following Final Completion. As evidence of coverage, Contractor shall furnish the actual policy to Owner prior to execution of the Contract.

G.3.6 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.

G.3.7 Certificate(s) of Insurance/Insurance Carrier Qualification: As evidence of the insurance coverage required by the Contract, the Contractor shall furnish certificate(s) of insurance to the Owner prior to execution of the Contract. The certificate(s) will specify all of the parties who are additional insureds or loss payees for the Contract. A renewal certificate shall be sent to Owner at least 10 days prior to coverage expiration. Insurance coverage required under the Contract shall be obtained from insurance companies or entities acceptable to the Owner and that are eligible to provide such insurance under Oregon law. Eligible insurers include admitted insurers that have been issued a certificate of authority from the Oregon Department of Consumer and Business Services authorizing them to conduct an insurance business and issue policies of insurance in the state of Oregon, and certain non-admitted surplus lines insurers that satisfy the requirements of applicable Oregon law and which are subject to approval by the Owner. The Contractor shall be financially responsible for all deductibles, self-insured retentions and/or self-insurance included hereunder. Any deductible, self-insured retention and/or self-insurance in excess of $50,000 shall be subject to approval by the Owner in writing and shall be a condition precedent to the effectiveness of any Contract.

SECTION H
SCHEDULE OF WORK

H.1 CONTRACT PERIOD

H.1.1 Time is of the essence. The Contractor shall at all times carry on the Work diligently, without delay and punctually fulfill all requirements herein.

H.1.2 Notice to Proceed. Unless otherwise directed in the Contract Documents, Contractor shall commence Work on the Project Site within fifteen (15) Days of the Notice to Proceed. Notwithstanding the Notice to Proceed, Contractor shall not be authorized to proceed with the Work until all initial Contract requirements, including the Contract, performance bond and payment bond, and certificates of insurance, have been fully executed and submitted in a form acceptable to Owner.

H.1.3 Unless otherwise not required in the Construction Documents, Contractor shall participate in a pre-construction conference with the Owner's representative and designated design team. The

purpose of this pre-construction conference is to review the Contractor's proposed Schedule of Values and to review any other Project logistics to be coordinated between the parties.

H.1.4 Unless specifically extended by a Change Order, all Work shall be complete by the date contained in the Contract Documents. The Owner shall have the right to accelerate the completion date of the Work, which may require the use of overtime. Such accelerated Work schedule shall be an acceleration in performance of Work under Section D.1.2(f) and shall be subject to the provisions of Section D.1.

H.1.5 The Owner shall not waive any rights under the Contract by permitting the Contractor to continue or complete in whole or in part the Work after the date described in Section H.1.2 above.

H.2 SCHEDULE

H.2.1 Contractor shall provide, by or before the pre-construction conference, the initial as-planned schedule for review and acceptance by the Owner. The submitted schedule must illustrate Work by Project components, labor trades, and long lead items broken down by building and/or floor where applicable. If Owner shall so elect, Contractor shall provide the schedule in CPM format showing the graphical network of planned activities, including i) a reasonably detailed list of all activities required to complete the Work; ii) the time and duration that each activity will take to completion; and iii) the dependencies between the activities. Schedules lacking adequate detail, or unreasonably detailed, will be rejected. The schedule shall include the following: Notice to Proceed or the date the Work commences, if no Notice to Proceed is issued by Owner, Substantial Completion, and Final Completion. Schedules shall be updated monthly, unless otherwise required by the Contract Documents, and submitted with the monthly application for payment. Acceptance of the Schedule by the Owner does not constitute agreement by the Owner as to the Contractor's sequencing, means, methods, or durations. Any positive difference between the Contractor's scheduled completion and the Contract completion date is float owned by the Owner. Owner reserves the right to negotiate the float if it is deemed to be in Owner's best interest to do so. In no case shall the Contractor make a claim for delays if the Work is completed within the Contract Time but after Contractor's scheduled completion.

H.2.2 All Work shall be completed during normal weekdays (Monday through Friday) between the hours of 7:00 a.m. and 5:00 p.m. unless otherwise specified in the Contract Documents. Unless otherwise specified in the Contract Documents, no Work shall be performed during the following holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving Day
- Christmas Day
- President's Day

When a holiday falls on a Sunday, the following Monday shall be recognized as a legal holiday. When a holiday falls on Saturday, the preceding Friday shall be recognized as a legal holiday.

H.3 PARTIAL OCCUPANCY OR USE

The Owner may occupy or use any completed or partially completed portion of the Work at any stage, provided such occupancy or use is consented to by public authorities having jurisdiction over the Work. Such partial occupancy or use may commence whether or not the portion is substantially complete, provided the Owner and Contractor have reasonably accepted in writing the responsibilities assigned to each of them. Approval by the Contractor to partial occupancy or use shall not be unreasonably withheld. Immediately prior to such partial occupancy or use, the Owner and Contractor shall jointly inspect the area to be occupied or portion of the Work to be used in order to determine and record the condition of the Work. Partial occupancy or use of a portion or portions of the Work shall not constitute acceptance of Work not complying with the requirements of the Contract Documents.

SECTION I
CORRECTION OF WORK

I.1 CORRECTION OF WORK BEFORE FINAL PAYMENT

The Contractor warrants to the Owner that materials and equipment furnished under the Contract will be of good quality and new unless otherwise required or permitted by the Contract Documents, that the Work will be free from defects, and that the Work will conform to the requirements of the Contract Documents. Work failing to conform to these requirements shall be deemed defective. Contractor shall promptly remove from the premises and replace all defective materials and equipment as determined by the Owner, whether incorporated in the Work or not. Removal and replacement shall be without loss or expense to the Owner, and Contractor shall bear the cost of repairing all Work destroyed or damaged by such removal or replacement. Contractor shall be allowed a period of no longer than thirty (30) Days after Substantial Completion for completion of defective (Punch List) work. At the end of the thirty-day period, or earlier if requested by the Contractor, Owner shall arrange for inspection of the Work by the Architect/Engineer. Should the work not be complete, and all corrections made, the costs for all subsequent reinspections shall be borne by the Contractor. If Contractor fails to complete the Punch List work within the thirty (30) Day period, Owner may perform such work and Contractor shall reimburse Owner all costs of the same within ten (10) Days after demand without affecting Contractor's obligations.

I.2 WARRANTY WORK

I.2.1 Neither the final certificate of payment nor any provision of the Contract Documents shall relieve the Contractor from responsibility for Defective Work and, unless a longer period is specified, Contractor shall correct all defects that appear in the Work within a period of one year from the date of issuance of the written notice of Substantial Completion by the Owner except for latent defects which will be remedied by the Contractor at any time they become apparent. The Owner shall give Contractor notice of defects with reasonable promptness. Contractor shall perform such warranty work within a reasonable time after Owner's demand and at Contractors sole expense. If Contractor fails to complete the warranty work within such period as Owner determines reasonable, or at any time in the event of warranty work consisting of emergency repairs, Owner may perform such work and Contractor shall reimburse Owner all costs of the same within ten (10) Days after demand, without affecting Contractor's obligations. The Contractor shall perform the warranty Work by correcting defects within twenty-four (24) hours of notification by Owner, unless otherwise specified in the Contract Documents. Should the Contractor fail to respond within the specified response time, the Owner may, at its option, complete the necessary repairs using another contractor or its agents. If Owner completes the repairs using Owner's agent, Contractor shall pay Owner at the rate of one and one-half (1½) times the standard hourly rate of Owner's agent, plus related overhead and any direct non-salary costs. If Owner completes the repairs using another contractor, Contractor shall pay Owner the amount of Owner's direct costs billed by the other contractor for the work, plus the direct salary costs and related overhead and direct non-salary expenses of Owner's agents who

are required to monitor that contractor's work. Work performed by Owner using Owner's own agents or those of another contractor shall not affect the Contractor's contractual duties under these provisions, including warranty provisions.

I.2.2 Nothing in this Section I.2 provision shall negate guarantees or warranties for periods longer than one year including without limitation, such guarantees or warranties required by other sections of the Contract Documents for specific installations, materials, processes, equipment or fixtures.

I.2.3 In addition to Contractor's warranty, manufacturer's warranties shall pass to the Owner and shall not take effect until such portion of the Work covered by the applicable warranty has been accepted in writing by the Owner.

I.2.4 The one-year period for correction of Work shall be extended with respect to portions of Work performed after Substantial Completion by the period of time between Substantial Completion and the actual performance of the Work, and shall be extended by corrective Work performed by the Contractor pursuant to this Section, as to the Work corrected. The Contractor shall remove from the Project Site portions of the Work which are not in accordance with the requirements of the Contract Documents and are neither corrected by the Contractor nor accepted by the Owner.

I.2.5 Nothing contained in this Section I.2 shall be construed to establish a period of limitation with respect to other obligations which the Contractor might have under the Contract Documents. Establishment of the period for correction of Work as described in this Section I.2 relates only to the specific obligation of the Contractor to correct the Work, and has no relationship to the time within which the obligation to comply with the Contract Documents may be sought to be enforced, nor to the time within which proceedings may be commenced to establish the Contractor's liability with respect to the Contractor's obligations other than specifically to correct the Work.

I.2.6 If the Owner prefers to accept Work which is not in accordance with the requirements of the Contract Documents, the Owner may do so instead of requiring its removal and correction, in which case the Contract Price will be reduced as appropriate and equitable as determined by Owner. Such adjustment shall be effected whether or not final payment has been made.

SECTION J
SUSPENSION AND/OR TERMINATION OF THE WORK

J.1 OWNER'S RIGHT TO SUSPEND THE WORK

J.1.1 The Owner has the authority to suspend portions or all of the Work due to the following causes:

(a) Failure of the Contractor to correct unsafe conditions;

(b) Failure of the Contractor to carry out any provision of the Contract;

(c) Failure of the Contractor to carry out orders;

(d) Conditions, in the opinion of the Owner, which are unsuitable for performing the Work;

(e) Time required to investigate differing Project Site conditions; or

(f) Any reason considered to be in the public interest.

J.1.2 The Owner shall notify Contractor and the Contractor's Surety in writing of the effective date and time of the suspension, and Owner shall notify Contractor and Contractor's surety in writing to resume Work.

J.2 CONTRACTOR'S RESPONSIBILITIES

J.2.1 During the period of the suspension, Contractor is responsible to continue maintenance at the Project just as if the Work were in progress. This includes, but is not limited to, protection of completed Work, maintenance of access, protection of stored materials, temporary facilities, and clean-up.

J.2.2 When the Work is recommenced after the suspension, the Contractor shall replace or renew any Work damaged during the suspension, remove any materials or facilities used as part of temporary maintenance, and complete the Work in every respect as though its prosecution had been continuous and without suspension.

J.3 COMPENSATION FOR SUSPENSION

Depending on the reason for suspension of the Work, the Contractor or the Owner may be due compensation by the other party. If the suspension was required due to acts or omissions of Contractor, the Owner may assess the Contractor actual costs of the suspension in terms of administration, remedial work by the Owner's agents or another contractor to correct the problem associated with the suspension, rent of temporary facilities, and other actual costs related to the suspension, and any liquidated damages arising from the delay. If the suspension was caused by acts or omissions of the Owner, the Contractor may be due compensation which shall be defined using Section D, Changes in Work. If the suspension was required through no fault of the Contractor or the Owner, neither party shall owe the other for the impact.

J.4 OWNER'S RIGHT TO TERMINATE CONTRACT

J.4.1 The Owner may, without prejudice to any other right or remedy, and after giving Contractor seven (7) Days' written notice and an opportunity to cure, terminate the Contract in whole or in part under the following conditions:

(a) If Contractor should, voluntarily or involuntarily, seek protection under the United States Bankruptcy Code and Contractor as debtor-in-possession or the Trustee for the estate fails to assume the Contract within a reasonable time;

(b) If Contractor should make a general assignment for the benefit of Contractor's creditors;

(c) If a receiver should be appointed on account of Contractor's insolvency;

(d) If Contractor should repeatedly refuse or fail to supply an adequate number of skilled workers or proper materials to carry on the Work as required by the Contract Documents, or otherwise fail to perform the Work in a timely manner;

(e) If Contractor should repeatedly fail to make prompt payment to Subcontractors or for material or labor, or should disregard laws, ordinances or the instructions of the Owner;

(f) If Contractor is otherwise in breach of any part of the Contract; or

(g) If Contractor is in violation of Applicable Laws, either in the conduct of its business or in its performance of the Work.

J.4.2 At any time that any of the above occurs, Owner may exercise all rights and remedies available to Owner at law or in equity, and, in addition, Owner may take possession of the premises and of all materials and appliances and finish the Work by whatever method it may deem expedient. In such case, the Contractor shall not be entitled to receive further payment until the Work is completed. If

the Owner's cost of finishing the Work exceeds the unpaid balance of the Contract Price, Contractor shall pay the difference to the Owner.

J.5 TERMINATION FOR CONVENIENCE, NON-APPROPRIATION OF FUNDS, OR FORCE MAJEURE

J.5.1 Owner may terminate the Contract in whole or in part whenever Owner determines: (a) that termination of the Contract is in the best interest of Owner or the public; (b) that the Owner failed to receive funding, appropriations, allocations or other expenditure authority as contemplated by Owner's budget and Owner determines, in its sole determination, and its assessment and ranking of the policy objectives explicit or implicit in Owner's budget, Owner may determine it is necessary to and may terminate the Contract.; or (c) in the event of Force Majeure.

J.5.2 The Owner shall provide the Contractor with seven (7) Days prior written notice of a termination for Owner's or for public convenience. After such notice, the Contractor shall provide the Owner with immediate and peaceful possession of the premises and materials located on and off the premises for which the Contractor received progress payment under Section E. Compensation for Work terminated by the Owner under this provision will be according to Section E. In no circumstance shall Contractor be entitled to lost profits for Work not performed due to termination. If the Contract is terminated for public convenience, neither the Contractor not its Surety shall be relieved of liability for damages or losses suffered by the Owner as a result of defective, unacceptable or unauthorized Work completed or performed.

J.6 ACTION UPON TERMINATION

J.6.1 Upon receiving a notice of termination, and except as directed otherwise by the Owner, Contractor shall immediately cease placing further subcontracts or orders for materials, services, or facilities. In addition, Contractor shall terminate all subcontracts or orders to the extent they relate to the Work terminated and, with the prior written approval of the Owner, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts and orders.

J.6.2 As directed by the Owner, Contractor shall, upon termination, transfer title and deliver to the Owner all Record Documents, information, and other property that, if the Contract had been completed, would have been required to be furnished to the Owner.

J.6.3 Upon Owner's notice of termination pursuant to either Section J.4 or J.5, if Owner shall so elect, Contractor shall assign to the Owner such subcontracts and orders as Owner shall specify. In the event Owner elects to take assignment of any such subcontract or order, Contractor shall take such action and shall execute such documents as Owner shall reasonably require for the effectiveness of such assignment and Contractor shall ensure that no contractual arrangement between it and its subcontractors or suppliers of any tier or sub-tier shall prevent such assignment.

SECTION K
CONTRACT CLOSE OUT

K.1 RECORD DOCUMENTS

As a condition of final payment (refer also to section E.6), Contractor shall comply with the following: Contractor shall provide Record Documents for the entire Project to Owner. Record Documents shall depict the Project as constructed and shall reflect each and every change, modification, and deletion made during the construction. Record Documents are part of the Work and shall be provided prior to the Owner's issuance of final payment. Record Documents include all modifications to the Contract Documents unless otherwise directed.

K.2 OPERATION AND MAINTENANCE MANUALS

As part of the Work, Contractor shall submit two completed operation and maintenance manuals ("O & M Manuals") for review by the Owner prior to submission of any pay request for more than 75% of the Work. Owner's receipt of the O & M Manuals shall be a condition precedent to any payment thereafter due. The O & M Manuals shall contain a complete set of all submittals, all product data as required by the specifications, training information, telephone list and contact information for all consultants, manufacturers, installer and suppliers, manufacturer's printed data, record and shop drawings, schematic diagrams of systems, appropriate equipment indices, warranties and bonds. The Owner shall review and return one O & M Manual for any modifications or adjustments required. Prior to submission of its final pay request, Contractor shall deliver two (2) complete and approved sets of O & M Manuals in paper form and one (1) complete and approved set in electronic form to the Owner and Owner's receipt of the O & M Manuals shall be a condition precedent to Owner's obligation to make final payment.

K.3 COMPLETION NOTICES

K.3.1 Contractor shall provide Owner written notice of both Substantial and Final Completion. The certificate of Substantial Completion shall state the date of Substantial Completion, the responsibilities of the Owner and Contractor for security, maintenance, heat, utilities, damage to the Work and insurance, and the time within which the Contractor shall finish all items on the Punch List accompanying the Certificate. Both completion notices must be signed and notarized by the Contractor and signed by the Architect/Engineer (if applicable) and Owner to be valid. The Owner shall provide the final signature on the notices. The notices shall take effect on the date they are signed by the Owner.

K.3.2 Substantial Completion of a facility with operating systems (e.g., mechanical, electrical, HVAC) shall be that degree of completion that has provided a minimum of thirty (30) continuous Days of successful, trouble-free operation, which period shall begin after all performance and acceptance testing has been successfully demonstrated to the Owner. All equipment contained in the Work, plus all other components necessary to enable the Owner to operate the facility in the manner that was intended, shall be complete on the Substantial Completion date. The Contractor may request that a Punch List be prepared by the Owner with submission of the request for the Substantial Completion notice.

K.4 TRAINING

As part of the Work, and prior to submission of the final application for payment, the Contractor shall schedule with the Owner training sessions for all equipment and systems as required by the Contract Documents. Contractor shall schedule training sessions at least two weeks in advance of the date of training to allow Owner to provide its personnel with adequate notice. If assignments arise because of termination under Section J.4, then such assignments shall not relieve Contractor of liability hereunder. The O & M Manual shall be used as a basis for training. In addition to any off-Project Site training required by the Contract Documents, training shall include a formal session conducted at the Project Site after the equipment and/or system is completely installed and operational in its normal operating environment.

K.5 EXTRA MATERIALS

As part of the Work, Contractor shall provide spare parts, extra maintenance materials, and other materials or products in the quantities specified in the Contract Documents prior to final payment. Delivery point for extra materials shall be designated by the Owner.

K.6 ENVIRONMENTAL CLEAN-UP

As part of the Final Completion notice, or as a separate written notice submitted with or before the notice of Final Completion, the Contractor shall notify the Owner that all environmental and pollution clean-up, remediation and closure have been completed in accordance with all Applicable Laws and pursuant to the authority of all agencies having jurisdiction, and Contractor shall provide Owner with any and all documentation related to the same, including but not limited to directives, orders, letters, certificates and permits related to or arising from such environmental pollution. The notice shall reaffirm the indemnification given under Section F.5.1 above. Contractor's completion of its obligations under this Section K.6 and Owner's receipt of documents evidencing such completion shall be a condition precedent to Owner's obligation to make final payment.

K.7 CERTIFICATE OF OCCUPANCY

Owner's receipt of an unconditioned certificate of occupancy from the appropriate state and/or local building officials shall be a condition precedent to Owner's obligation to make final payment, except to the extent failure to obtain an unconditional certificate of occupancy is due to the fault or neglect of Owner.

K.8 OTHER CONTRACTOR RESPONSIBILITIES

The Contractor shall be responsible for returning to the Owner all property of Owner issued to Contractor during construction such as keys, security passes, Project Site admittance badges, and all other pertinent items. Upon notice from Owner, Contractor shall be responsible for notifying the appropriate utility companies to transfer utility charges from the Contractor to the Owner. The utility transfer date shall not be before Substantial Completion and may not be until Final Completion, if the Owner does not take beneficial use of the facility and the Contractor's agents continue with the Work.

The Owner's property is drug free and weapons free areas and the use of tobacco products is only allowed in designated areas. Contractor shall be required to ensure that its employees, Subcontractors and agents shall comply with these requirements.

SECTION L
GENERAL PROVISIONS

L.1 NO THIRD PARTY BENEFICIARIES

Owner and Contractor are the only parties to the Contract and are the only parties entitled to enforce its terms. Nothing in the 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 the Contract.

L.2 SEVERABILITY

If any provision of the Contract is declared by a court to be unenforceable, 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 provision held to be invalid.

L.3 ACCESS TO RECORDS

L.3.1 Contractor shall keep, at all times on the Project Site, one record copy of the complete Contract Documents, including the Plans, Specifications, addenda, and Change Orders (if any) in good order and marked currently to record field changes and selections made during construction, and one record copy of Shop Drawings, Product Data, Samples and similar submittals, and shall at all times give the Owner access thereto.

L.3.2 Contractor shall retain and the Owner and its duly authorized representatives shall have access, for a period not less than ten (10) years, to all Record Documents, financial and accounting records, and other books, documents, papers and records of Contractor which are pertinent to the Contract, including records pertaining to Overhead and indirect costs, for the purpose of making audit, examination, excerpts and transcripts. If for any reason, any part of the Work or the Contract shall be subject to litigation, Contractor shall retain all such records until all litigation is resolved and Contractor shall continue to provide Owner and/or its agents with full access to such records until such time as all litigation is complete and all periods for appeal have expired and full and final satisfaction of any judgment, order or decree is recorded and Owner receives a record copy of documentation from Contractor.

L.4 WAIVER

Failure of the Owner to enforce any provision of the Contract shall not constitute a waiver or relinquishment by the Owner of the right to such performance in the future nor of the right to enforce any other provision of the Contract.

L.5 SUCCESSORS IN INTEREST

The provisions of the Contract shall be binding upon and shall accrue to the benefit of the parties to the Contract and their respective permitted successors and assigns.

L.6 GOVERNING LAW

The Contract shall be governed by and construed in accordance with the laws of the State of Oregon without giving effect to the conflict of law provisions thereof.

L.7 APPLICABLE LAW

Contractor hereto agrees to comply in all ways with applicable local, state and federal ordinances, statutes, laws and regulations.

L.8 NON-EXCLUSIVE RIGHTS AND REMEDIES

Except as otherwise expressly provided herein, the rights and remedies expressly afforded under the provisions of the Contract 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.

L.9 INTERPRETATION

The titles of the sections of the Contract are inserted for convenience of reference only and shall be disregarded in construing or interpreting any of its provisions.

L.10 DEBT LIMITATION

The 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.

L.11 LITIGATION

Any Claim between Owner and Contractor that arises from or relates to the Contract and that is not resolved through the Claims Review Process in Section D.3 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. CONTRACTOR, BY EXECUTION OF THE CONTRACT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF THE COURTS REFERENCED IN THIS SECTION.

L. 12 SURVIVAL

All warranty, indemnification, and record retention provisions of the Contract, and all of Contractor's other obligations under the Contract that are not fully performed by the time of Final Completion or termination, and all other rights and obligations which by their context are intended to survive, shall survive Final Completion or any termination of the Contract.

L.13 ACCESS TO RECORDS

L.13.1. Contractor shall keep, at all times on the Work site, one record copy of the complete Contract Documents, including the Plans, Specifications, Construction Change Directives and addenda, in good order and marked currently to record field changes and selections made during construction, and one copy of Shop Drawings, Project Data, Samples and similar submittals, and shall at all times give the Owner access thereto.

L.13.2 Contractor shall retain and the Owner and its duly authorized representatives shall have access, for a period not less than ten (10) years, to all Record Documents, financial and accounting records, and other books, documents, papers and records of Contractor which are pertinent to the Contract, including records pertaining to Overhead and indirect costs, for the purpose of making audit, examination, excerpts and transcripts. If for any reason, any part of the Work or this Contract shall be subject to litigation, Contractor shall retain all such records until all litigation is resolved and Contractor shall continue to provide Owner and/or its agents with full access to such records until such time as all litigation is complete and all periods for appeal have expired and full and final satisfaction of any judgment, order or decree is recorded and Owner receives a record copy of documentation from Contractor.

L.14 WAIVER

Failure of the Owner to enforce any provision of this Contract shall not constitute a waiver or relinquishment by the Owner of the right to such performance in the future nor of the right to enforce any other provision of this Contract.

L. 15 NO ATTORNEY FEES.

In the event any arbitration, action or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Contract, each party shall be responsible for its own attorneys' fees and expenses.

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT

PERFORMANCE BOND

Bond No.: 4446826
Solicitation: #2021-79
Project Name: CBX Fiber WCCCA Connection

MARKEL INSURANCE COMPANY (Surety #1)	Bond Amount No. 1:	$ 179,000.00
_____ (Surety #2) *	Bond Amount No. 2: *	$ _____
* *If using multiple sureties*	Total Penal Sum of Bond:	$ 179,000.00

We, NORTHSTAR ELECTRICAL CONTRACTORS, INC. as Principal, and the above identified Surety(ies), authorized to transact surety business in Oregon, as Surety, hereby jointly and severally bind ourselves, our respective heirs, executors, administrators, successors and assigns firmly by these presents to pay unto Clackamas County and the City of Hillsboro, the sum of (Total Penal Sum of Bond) ONE HUNDRED SEVENTY NINE THOUSAND NO/100**($179,000.00) (Provided, that we the Sureties bind ourselves in such sum "jointly and severally" as well as "severally" only for the purpose of allowing a joint action or actions against any or all of us, and for all other purposes each Surety binds itself, jointly and severally with the Principal, for the payment of such sum only as is set forth opposite the name of such Surety); and

WHEREAS, the Principal has entered into a contract with Clackamas County and the City of Hillsboro, along with the plans, specifications, terms and conditions of which are contained in the above-referenced Solicitation; and

WHEREAS, the terms and conditions of the contract, together with applicable plans, standard specifications, special provisions, schedule of performance, and schedule of contract prices, are made a part of this Performance Bond by reference, whether or not attached to the contract (all hereafter called "Contract"); and

WHEREAS, the Principal has agreed to perform the Contract in accordance with the terms, conditions, requirements, plans and specifications, and all authorized modifications of the Contract which increase the amount of the work, the amount of the Contract, or constitute an authorized extension of the time for performance, notice of any such modifications hereby being waived by the Surety:

NOW, THEREFORE, THE CONDITION OF THIS BOND IS SUCH that if the Principal herein shall faithfully and truly observe and comply with the terms, conditions and provisions of the Contract, in all respects, and shall well and truly and fully do and perform all matters and things undertaken by Contractor to be performed under the Contract, upon the terms set forth therein, and within the time prescribed therein, or as extended as provided in the Contract, with or without notice to the Sureties, and shall defend, indemnify, and save harmless Clackamas County, the City or Hillsboro, and its elected officials, officers, employees and agents, against any direct or indirect damages or claim of every kind and description that shall be suffered or claimed to be suffered in

connection with or arising out of the performance of the Contract by the Principal or its subcontractors, and shall in all respects perform said contract according to law, then this obligation is to be void; otherwise, it shall remain in full force and effect for so long as any term of the Contract remains in effect.

Nonpayment of the bond premium will not invalidate this bond nor shall Clackamas County and the City of Hillsboro, be obligated for the payment of any premiums.

This bond is given and received under authority of Oregon Revised Statutes Chapter 279C and the Clackamas County Local Contractor Review Board Rules, the provisions of which hereby are incorporated into this bond and made a part hereof.

IN WITNESS WHEREOF, WE HAVE CAUSED THIS INSTRUMENT TO BE EXECUTED AND SEALED BY OUR DULY AUTHORIZED LEGAL REPRESENTATIVES.

Dated this 30th day of October, 2021.

PRINCIPAL: NORTHSTAR ELECTRICAL CONTRACTORS, INC

By: _____
Signature

President
Official Capacity

Attest: _____
Corporation Secretary

SURETY: MARKEL INSURANCE COMPANY
[Add signatures for each if using multiple bonds]

BY ATTORNEY-IN-FACT:
[Power-of-Attorney must accompany each bond]

ROBIN BAIRD
Name

Robin Baird
Signature

2103 CITY WEST BLVD STE 1300
Address

HOUSTON TX 77042
City State Zip

541-741-0550 541-741-1674
Phone Fax

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT

PAYMENT BOND

Bond No.: 4446826
Solicitation: #2021-79
Project Name: CBX Fiber WCCCA Connection

MARKEL INSURANCE COMPANY (Surety #1)	Bond Amount No. 1:	$ 179,000.00
_____ (Surety #2)*	Bond Amount No. 2:*	$ _____
* *If using multiple sureties*	Total Penal Sum of Bond:	$ 179,000.00

We, NORTHSTAR ELECTRICAL CONTRACTORS, INC., as Principal, and the above identified Surety(ies), authorized to transact surety business in Oregon, as Surety, hereby jointly and severally bind ourselves, our respective heirs, executors, administrators, successors and assigns firmly by these presents to pay unto Clackamas County and the City of Hillsboro, the sum of (Total Penal Sum of Bond) ONE HUNDRED SEVENTY NINE THOUSAND NO/100**($179,000.00) (Provided, that we the Sureties bind ourselves in such sum "jointly and severally" as well as "severally" only for the purpose of allowing a joint action or actions against any or all of us, and for all other purposes each Surety binds itself, jointly and severally with the Principal, for the payment of such sum only as is set forth opposite the name of such Surety); and

WHEREAS, the Principal has entered into a contract with Clackamas County and the City of Hillsboro, along with the plans, specifications, terms and conditions of which are contained in above-referenced Solicitation; and

WHEREAS, the terms and conditions of the contract, together with applicable plans, standard specifications, special provisions, schedule of performance, and schedule of contract prices, are made a part of this Payment Bond by reference, whether or not attached to the contract (all hereafter called "Contract"); and

WHEREAS, the Principal has agreed to perform the Contract in accordance with the terms, conditions, requirements, plans and specifications, and schedule of contract prices which are set forth in the Contract and any attachments, and all authorized modifications of the Contract which increase the amount of the work, or the cost of the Contract, or constitute authorized extensions of time for performance of the Contract, notice of any such modifications hereby being waived by the Surety:

NOW, THEREFORE, THE CONDITION OF THIS BOND IS SUCH that if the Principal shall faithfully and truly observe and comply with the terms, conditions and provisions of the Contract, in all respects, and shall well and truly and fully do and perform all matters and things by it undertaken to be performed under said Contract and any duly authorized modifications that are made, upon the terms set forth therein, and within the time prescribed therein, or as extended therein as provided in the Contract, with or without notice to the Sureties, and shall defend, indemnify, and save harmless Clackamas County, the City of Hillsboro, and its elected officials, officers, employees and agents, against any claim for direct or indirect damages of every kind and description that shall be suffered or claimed to be suffered in connection with or arising out of the performance of the Contract by the Contractor or its subcontractors, and shall promptly pay all persons supplying labor, materials or both to the Principal or its subcontractors for prosecution of the work provided in the Contract; and shall promptly pay all contributions due the State Industrial Accident Fund and the State Unemployment Compensation Fund from the Principal or its subcontractors in connection with the

performance of the Contract; and shall pay over to the Oregon Department of Revenue all sums required to be deducted and retained from the wages of employees of the Principal and its subcontractors pursuant to ORS 316.167; and shall permit no lien nor claim to be filed or prosecuted against Clackamas County and the City of Hillsboro on account of any labor or materials furnished; and shall do all things required of the Principal by the laws of this State, then this obligation shall be void; otherwise, it shall remain in full force and effect for so long as any term of the Contract remains in effect.

Nonpayment of the bond premium will not invalidate this bond nor shall Clackamas County and the City of Hillsboro be obligated for the payment of any premiums.

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Dated this 30th day of October, 2021.

PRINCIPAL: NORTHSTAR ELECTRICAL CONTRACTORS, INC

By: _____
Signature

President
Official Capacity

Attest: _____
Corporation Secretary

SURETY: MARKEL INSURANCE COMPANY
[Add signatures for each if using multiple bonds]

BY ATTORNEY-IN-FACT:
[Power-of-Attorney must accompany each bond]

ROBIN BAIRD
Name

Robin Baird
Signature

2103 CITY WEST BLVD STE 1300
Address

HOUSTON TX 77042
City State Zip

541-741-0550 541-741-1674
Phone Fax

POA# 3710043

JOINT LIMITED POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That SureTec Insurance Company, a Corporation duly organized and existing under the laws of the State of Texas and having its principal office in the County of Harris, Texas and Markel Insurance Company (the "Company"), a corporation duly organized and existing under the laws of the state of Illinois, and having its principal administrative office in Glen Allen, Virginia, does by these presents make, constitute and appoint

Michelle Bench, Robin Baird, Kyle Hudson, Keith Yam, Ken Price, William Kaufmann

Their true and lawful agent(s) and attorney(s) in-fact, each in their separate capacity if more than one is named above, to make, execute, seal and deliver for and on their own behalf, individually as a surety or jointly, as co-sureties, and as their act and deed any and all bonds and other undertaking in suretyship provided, however, that the penal sum of any one such instrument executed hereunder shall not exceed the sum of:

Fifty Million and 00/100 Dollars ($50,000,000.00)

This Power of Attorney is granted and is signed and sealed under and by the authority of the following Resolutions adopted by the Board of Directors of SureTec Insurance Company and Markel Insurance Company:

"RESOLVED, That the President, any Senior Vice President, Vice President, Assistant Vice President, Secretary, Assistant Secretary, Treasurer or Assistant Treasurer and each of them hereby is authorized to execute powers of attorney, and such authority can be executed by use of facsimile signature, which may be attested or acknowledged by any officer or attorney, of the company, qualifying the attorney or attorneys named in the given power of attorney, to execute in behalf of, and acknowledge as the act and deed of the SureTec Insurance Company and Markel Insurance Company, as the case may be, all bond undertakings and contracts of suretyship, and to affix the corporate seal thereto."

IN WITNESS WHEREOF, Markel Insurance Company and SureTec Insurance Company have caused their official seal to be hereunto affixed and these presents to be signed by their duly authorized officers on the 3rd day of September , 2021 .

SureTec Insurance Company

By: _____
Michael C. Keimig, President

Markel Insurance Company

By: _____
Lindey Jennings, Vice President

State of Texas
County of Harris:

On this 3rd day of September , 2021 A. D., before me, a Notary Public of the State of Texas, in and for the County of Harris, duly commissioned and qualified, came THE ABOVE OFFICERS OF THE COMPANIES, to me personally known to be the individuals and officers described in, who executed the preceding instrument, and they acknowledged the execution of same, and being by me duly sworn, disposed and said that they are the officers of the said companies aforesaid, and that the seals affixed to the proceeding instrument are the Corporate Seals of said Companies, and the said Corporate Seals and their signatures as officers were duly affixed and subscribed to the said instrument by the authority and direction of the said companies, and that Resolutions adopted by the Board of Directors of said Companies referred to in the preceding instrument is now in force.

IN TESTIMONY WHEREOF, I have hereunto set my hand, and affixed my Official Seal at the County of Harris, the day and year first above written.

XENIA CHAVEZ
Notary Public, State of Texas
Notary ID# 12911765-9
My Commission Expires
SEPTEMBER 10, 2024

By: _____
Xenia Chavez, Notary Public
My commission expires 9/10/2024

We, the undersigned Officers of SureTec Insurance Company and Markel Insurance Company do herby certify that the original POWER OF ATTORNEY of which the foregoing is a full, true and correct copy is still in full force and effect and has not been revoked.

IN WITNESS WHEREOF, we have hereunto set our hands, and affixed the Seals of said Companies, on the 30 day of October , 2021 .

SureTec Insurance Company

By: _____
M. Brent Beaty, Assistant Secretary

Markel Insurance Company

By: _____
Andrew Marquis, Assistant Secretary

Any Instrument issued in excess of the penalty stated above is totally void and without any validity. 3710043
For verification of the authority of this Power you may call (713)812-0800 on any business day between 8:30 AM and 5:00 PM CST.

CLACKAMAS COUNTY

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT
PROJECT INFORMATION, PLANS, SPECIFICATIONS AND DRAWINGS

PROJECT: #2021-79 CBX Fiber WCCCA Connection

Project Scope:
See attached drawings for design.
Bids will be lump sum for complete project. Total cost shall include traffic control and potholing of existing utilities. Full panel concrete restoration will also be required.
Note: include a per-foot rock adder cost.

Avoid touching/breaking ADA ramps when potholing or exposing drill head.

Payments to contractor will be approved and conducted through the City of Hillsboro.

Splicing Requirements:
N/A – Splicing will be completed under a different contract.

Material Requirements:
- Fiber Optic Cable: Provided by CBX, placed by the contractor
- Splice Case: N/A
- Conduit: 2" HDPE and 1" HDPE (CBX provided; Contractor Installed)
- Vaults: All vaults provided by CBX, placed by the contractor
- Risers: N/A
- Strand: N/A
- Premise Terminations: N/A

General Requirements:
1. All material and equipment needed to complete this project, with the exception of the list provided above, will be supplied by the contractor.
2. All utility make-ready costs will be the responsibility of Clackamas CBX.
3. City permit will be provided by CBX.
4. Contractor will be responsible for developing an approved traffic control plan. All flagging costs need to be included in the bid.
5. Place locate wire in all conduit that fiber is placed in.
6. CBX is not responsible for extra costs due to Subcontractors failure to review complete plans, drawings and specifications.

Project Estimate: $250,000.00

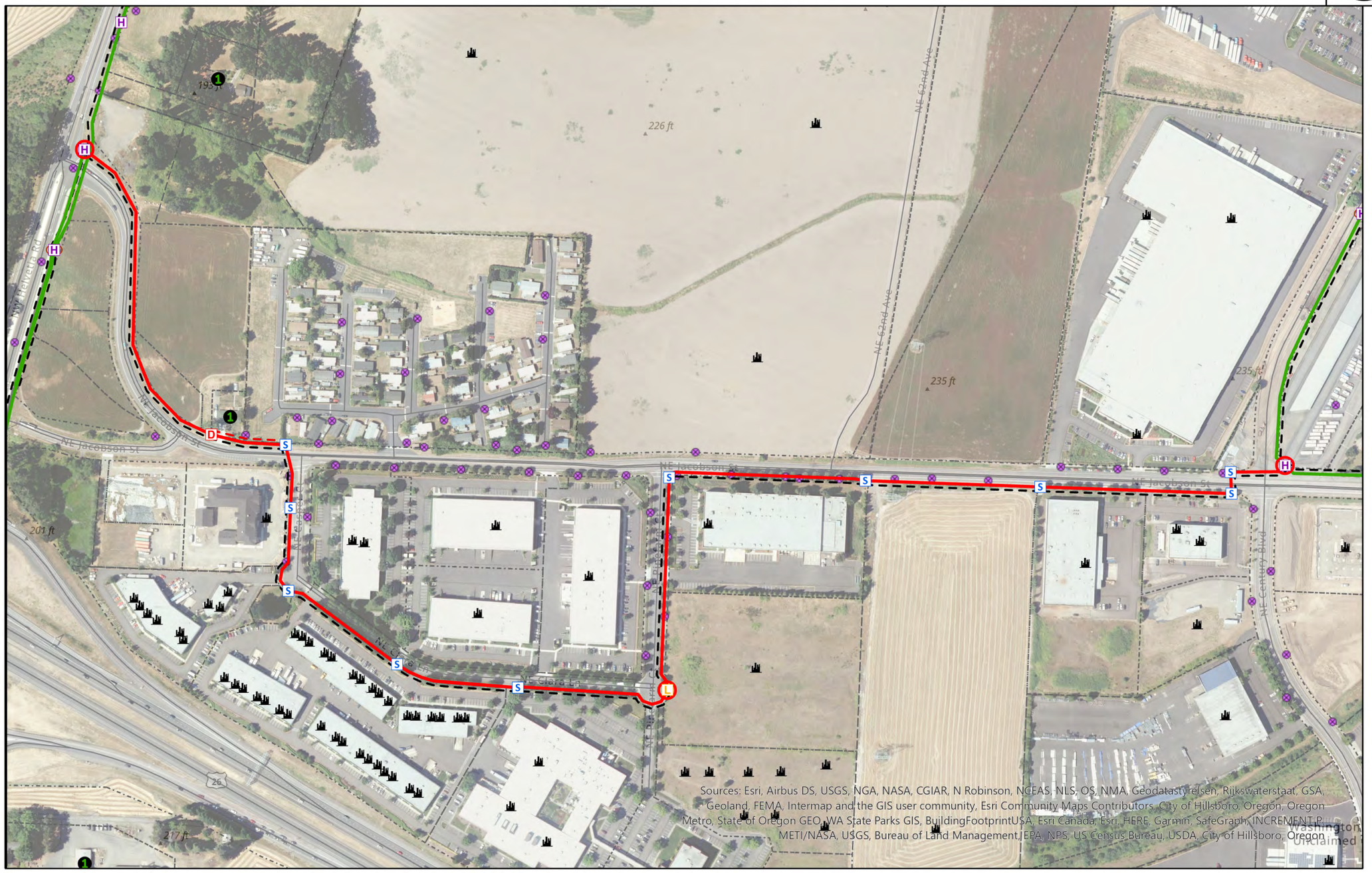
Key Dates:
All Basic Bid Work may begin as soon as the Notice to Proceed ("NTP") is issued
Substantial Completion: 90 days from NTP
Final Completion: 120 days from NTP

Time is of the essence for this Project.

The Scope further includes the following Plans, Specifications and Drawings:

- FIBER OPTIC CABEL ROUTE drawing set; 12 pages.

HILLSBORO, OREGON
WASHINGTON COUNTY



**** NOTE ****
CONDUIT SHOULD BE PLACED
IN THE PUE WHERE AVAILABLE

CAUTION!!!
CONTRACTOR TO LOCATE &
VERIFY ALL EXISTING UTILITIES
PRIOR TO CONSTRUCTION

**** NOTE ****
UTILITY & R.O.W. REPRESENTED ON
PLANS ARE BASED ON RECORDS
INFORMATION. NOT BASED ON
BOUNDARY SURVEY & FIELD EXPOSURES.

**** NOTE ****
ALL CONDUIT TO BE PLACED AT
36" MINIMUM DEPTH UNLESS NOTED

0 180 360 720 FT

Magellan ADVISORS

Hillsboro 911 Center

MAGELLAN ADVISORS
HIOBB LINK

TITLE: FIBER OPTIC CABLE ROUTE

HIOBB OUTSIDE PLANT
UNDERGROUND ROW PERMIT/DESIGN
CITY OF HILLSBORO

DATE:	04/09/21
ENGINEER: SM	
DRAWN BY: MA	

REVISIONS

DATE	DESCRIPTION	INITIAL

HiLight

Oregon 811
UTILITY NOTIFICATION CENTER

SCALE

HORIZONTAL:	1:3,600
VERTICAL:	1:3,600
MP	TO MP
SHEET	OF 138

HILLSBORO, OREGON
WASHINGTON COUNTY

Address

- Commercial
- Government
- Industrial
- Multi Family Residence
- School
- Single Family Residence
- Unknown
- Vacant
- <all other values>

Structure

- 11x18
- 24x36
- 30x48
- Existing HH

Splice Closure

- Aerial NAP
- Aerial NAP/MCA
- MCA
- Other
- Reel End
- UG NAP
- UG NAP/MCA
- FDH Cabinet
- Slackloop

Conduit

- 1"
- 2"
- 4"
- Do Not Build
- Hillsboro Poles
- Hillsboro Base - WC Streets

Hillsboro Base - WC Arterials

Metro Classification

- 1100 - 1110
- 1111 - 1421

Fibercable

Category,Status

- BB,Existing
- BB,Prelim
- DimensionLine

July 2018 6in

- Red: Band_1 Red: Band_1
- Green: Band_2 Green: Band_2
- Blue: Band_3 Blue: Band_3

**** NOTE ****
CONDUIT SHOULD BE PLACED
IN THE PUE WHERE AVAILABLE

CAUTION!!!
CONTRACTOR TO LOCATE &
VERIFY ALL EXISTING UTILITIES
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Magellan ADVISORS

Legend

MAGELLAN ADVISORS

HIOBB LINK

TITLE: FIBER OPTIC CABLE ROUTE

FTTH OUTSIDE PLANT
UNDERGROUND ROW PERMIT/DESIGN
CITY OF HILLSBORO

DATE:	04/09/21
ENGINEER: SM	
DRAWN BY: MA	

REVISIONS

DATE	DESCRIPTION	INITIAL

HiLight

Oregon811 UTILITY NOTIFICATION CENTER

SCALE

HORIZONTAL:	1:279,502,278
VERTICAL:	1:279,502,278
MP	TO MP
SHEET	OF 138

HILLSBORO, OREGON
WASHINGTON COUNTY

LOCATES

1. OREGON LAW REQUIRES YOU TO FOLLOW RULES ADOPTED BY THE OREGON UTILITY NOTIFICATION CENTER. THOSE RULES ARE FORTH IN OAR 952-001-0010 THROUGH OAR 952-001-0090 AND ORS 757.541 TO 757.571. YOU MAY OBTAIN COPIES OF THE RULES BY CALLING THE NOTIFICATION CENTER AT 503-246-6699.
THE CONTRACTOR SHALL HAVE A COPY OF THE APPROVED PERMIT INCLUDING ALL ATTACHMENTS AND A SET OF APPROVED CONSTRUCTION DRAWINGS ON SITE AT ALL TIMES.

2. ALL LOCATE REQUESTS SHALL BE PRECEDED BY HAVING THE AREA PRE-MARKED WITH WHITE PAINT.

AUTHORIZED PERIODS OF WORK

1. CONTRACTORS SHALL PROMPTLY COMPLETE ALL CONSTRUCTION ACTIVITIES SO AS TO MINIMIZE DISRUPTION OF THE CITY RIGHT-OF-WAYS AND OTHER PUBLIC AND PRIVATE PROPERTY.

2. ALL CONSTRUCTION WORK WITHIN RIGHTS-OF-WAY, INCLUDING RESTORATION, MUST BE COMPLETED WITHIN 120 DAYS OF THE DATE OF ISSUANCE OF THIS PERMIT UNLESS AN EXTENSION OR AN ALTERNATE SCHEDULE HAS BEEN APPROVED BY THE APPROPRIATE CITY OFFICIAL.

EROSION CONTROL

1. ALL APPLICABLE EROSION CONTROL MEASURES SHALL BE IN PLACE PRIOR TO THE START OF CONSTRUCTION AND SHALL BE MAINTAINED THROUGHOUT THE ENTIRE PROJECT.

2. ALL EXPOSED SOILS WITHIN THE CWS WET WEATHER MEASURE DATES, NEED EITHER A 6-MILL PLASTIC SHEET COVER OR A 2" MINIMUM STRAW MULCH COVER AS PER CHAPTER 8 OF CLEAN WATER SERVICES DESIGN AND CONSTRUCTION STANDARDS.

3. THIS PRIMARILY APPLIES TO, BUT IS NOT LIMITED TO, OPEN TRENCHING INSTALLATION. SOILS FROM BORE PIT EXCAVATION MUST BE COVERED WITH VISQUEEN AT THE END OF EACH WORKING DAY IF STILL ON-SITE.

TRAFFIC CONTROL

1. CITY STREETS ARE NOT ALLOWED TO BE CLOSED UNLESS PRIOR APPROVAL IS GRANTED.

2. PEDESTRIAN AND BICYCLE TRAFFIC ACCOMMODATIONS SHALL BE MADE TO ENSURE SAFE PASSAGE THROUGH OR AROUND WORK SITES.

3. TRAFFIC CONTROL SHALL BE PERFORMED IN ACCORDANCE TO THE OREGON TEMPORARY TRAFFIC CONTROL HANDBOOK FOR OPERATIONS OF THREE DAYS OR LESS OR M.U.T.C.D. IF LONGER.

4. A TRAFFIC CONTROL PLAN WILL BE REQUIRED FOR ANY TEMPORARY DIVERSION OR CLOSURE OF HILLSBORO STREETS IF THE DIVERSION OR CLOSURE TO THE RIGHT-OF-WAY IS LONGER THAN 15 MINUTES. ALL TRAFFIC CONTROL PLAN WILL REQUIRE APPROVAL OF THE CITY ENGINEER PRIOR TO COMMENCEMENT OF WORK.

CONSTRUCTION STANDARDS

1. THE APPLICANT IS RESPONSIBLE FOR THE LOCATION OF ALL UTILITIES WITHIN THE WORK AREA AND IS REQUIRED TO NOTIFY ALL APPLICABLE UTILITY COMPANIES 48-HOURS, BEFORE COMMENCEMENT OF WORK.

2. POTHOLING IS REQUIRED PRIOR TO CROSSING ANY CITY-OWNED UTILITY.

3. APPLICANT MUST MAINTAIN MINIMUM VERTICAL AND HORIZONTAL CLEARANCES FROM EXISTING UTILITIES AT ALL TIMES AND AVOID CROSSING AT HIGHLY ACUTE ANGLES.

4. THE FOLLOWING HORIZONTAL CLEARANCES SHALL BE MAINTAINED:
- CABLE TV - 5'
- NATURAL GAS - 5'
- ELECTRICAL - 5'
- STORM SEWER - 5'
- SANITARY SEWER - 10' OR AS ALLOWED BY OAR 333-061-0050
- TELEPHONE, FIBER OPTICS - 5'
- OTHER (NOT SPECIFIED) - 5' OR AS REQUIRED BY THE WATER DEPARTMENT

5. THE FOLLOWING VERTICAL CLEARANCES SHALL BE MAINTAINED
- CABLE TV - 12"
- NATURAL GAS - 12"
- ELECTRICAL - 12"
- STORM SEWER - 12"
- SANITARY SEWER - 18" OR AS ALLOWED BY OAR 333-061-0050
- TELEPHONE, FIBER OPTICS - 12"
- OTHER (NOT SPECIFIED) - 12" OR AS REQUIRED BY THE WATER DEPARTMENT

6. ALL UTILITIES SHALL CROSS UNDER WATER PIPING AND APPURTENANCES UNLESS OTHERWISE AUTHORIZED BY THE WATER DEPARTMENT ENGINEERING MANAGER.

7. 2" CITY FIBER DISTRIBUTION LINE CONDUIT SHALL BE INSTALLED ALONG STREET FRONTAGE IN THE PUBLIC UTILITY EASEMENT (IF AVAILABLE) OR WITHIN STREET RIGHT-OF-WAY FOR ALL RESIDENTIAL AND COMMERCIAL CONSTRUCTION PROJECTS.

8. ALL TRENCHES SHALL BE A MINIMUM OF 36 INCHES IN DEPTH, BACKFILLED WITH CLEAN ¾" MINUS CRUSHED ROCK, COMPACTED IN 2 FOOT MAXIMUM LIFTS TO 95% AASHTO T-99 TEST METHOD.

9. TRENCHES IN UNIMPROVED ROADWAYS (WITHOUT CURBS) MUST BE A MINIMUM OF 48" IN DEPTH AND ADHERE TO THE SAME COMPACTION TEST (THIS STIPULATION ALSO APPLIES TO JOINT TRENCH INSTALLATION IN NEWLY CONSTRUCTION STREETS).
THE CITY OF HILLSBORO SHALL BE SUPPLIED WITH COMPACTION TEST RESULTS FROM A CERTIFIED TESTING LABORATORY.

10. TEMPORARY COLD MIX ASPHALT REPAIR IS ALLOWABLE. THE TEMPORARY REPAIR SHALL BE RECONSTRUCTED IN ACCORDANCE WITH THE CITY OF HILLSBORO DESIGN AND CONSTRUCTION STANDARDS, WITHIN SEVEN CALENDAR DAYS.

11. ALL STREET CUTS 9 SQUARE FEET OR GREATER WILL REQUIRE A COMPACTION TEST ON THE BASE AND ASPHALT. IN PLACE DENSITY TESTS WILL BE REQUIRED FOR FIRST LIFT 91% COMPACTION AND 92% FOR ANY OTHERS.

12. THE CITY OF HILLSBORO HAS A 5 YEAR MORATORIUM ON CUTTING NEWLY CONSTRUCTED STREETS AND STREET OVERLAYS.

13. ALL ASPHALT STREET TRENCHES SHALL BE SAW CUT.

14. CONCRETE STREET TRENCHES SHALL BE SAW CUT.

15. CONCRETE STREET TRENCHING SHALL BE ACCOMPLISHED BY THE REMOVAL AND REPLACEMENT OF FULL PANELS, WHERE DOWELING WILL BE UTILIZED.

RESTORATION

1. WHEN A CONTRACTOR DOES ANY WORK IN OR AFFECTING ANY RIGHTS-OF-WAY, IT SHALL AT ITS OWN EXPENSE, TO PROMPTLY RESTORE SUCH WAY OR PROPERTY TO AT LEAST THE SAME CONDITION THAT IT WAS IN PRIOR TO EXCAVATION IN ACCORDANCE WITH APPLICABLE FEDERAL, STATE AND LOCAL LAWS.

2. WHEN SIDEWALK PANELS MUST BE REMOVED FOR INSTALLATION PURPOSES, ONLY FULL PANELS ARE TO BE REPLACED TO AN ORIGINAL OR BETTER CONDITION.

3. ALL NEW PANELS ARE TO BE EDGE-SHINED ON ALL 4 SIDES OR MATCH EXISTING.

4. ANY WATER METERS IN EXISTING PANELS MUST BE RESET TO MATCH THE ELEVATION OF THE FRESH CONCRETE SO AS TO NOT CREATE A TRIPPING HAZARD.

5. THE WATER DEPARTMENT WILL PROVIDE NEW METER BOXES FOR ONES NEEDING REPLACEMENT. CONTACT THE WATER DEPARTMENT AT 503-615-6700.

6. THE NEW PANELS MUST BE COVERED DURING INCLEMENT WEATHER TO ALLOW ADEQUATE CURE TIME.

7. ALL DISTURBED LANDSCAPED AREAS (TREES, SHRUBS, GRASS, FLOWERS, ETC) DAMAGED DURING THE PROJECT SHALL BE RESTORED BY THE GRANTEE OR CONTRACTOR TO ORIGINAL OR BETTER CONDITION.

8. WHEN WORKING NEAR STREET TREES, STAY OUTSIDE OF ITS DRIP LINE.

9. EXISTING SURVEY MONUMENTS ARE TO BE PROTECTED DURING CONSTRUCTION OR REPLACED IN ACCORDANCE WITH OREGON REVISED STATUTES 209.140 - 209.155 AT THE EXPENSE OF THE GRANTEE OR CONTRACTOR.

10. A PROFESSIONAL PLUMBER AT THE EXPENSE OF THE GRANTEE OR CONTRACTOR MUST REPAIR ANY DAMAGE TO EXISTING PLUMBING LINES OR PRIVATE PROPERTY (LATERALS).

11. IT IS SUGGESTED THAT THE GRANTEE OR CONTRACTOR PERFORM A SITE INSPECTION PRIOR TO COMMENCEMENT OF WORK AND ANY EXISTING DEFECTS SHOULD BE RECORDED. THIS PROCEDURE WILL HELP TO PREVENT ANY UNDUE DAMAGED BEING LOBBIED AGAINST THE CONTRACTOR.

12. IF THE CONTRACTOR FAILS TO RESTORE RIGHTS-OF-WAY OR PROPERTY AS REQUIRED IN THE PERMIT, THE CITY SHALL GIVE THE CONTRACTOR WRITTEN NOTICE AND PROVIDE A REASONABLE PERIOD OF TIME NOT LESS THAN 10-DAYS, UNLESS A THREAT TO PUBLIC SAFETY IS DEEMED TO EXIST, AND NOT EXCEEDING 30 DAYS TO RESTORE THE RIGHTS-OF-WAY OR PROPERTY.

13. IF, AFTER SAID NOTICE, THE CONTRACTOR OR GRANTEE OF THIS PERMIT FAILS TO RESTORE THE RIGHTS-OF-WAY OR PROPERTY AS REQUIRED IN THE PERMIT, THE CITY SHALL CAUSE SUCH RESTORATION TO BE MADE AT THE EXPENSE OF THE CONTRACTOR OR GRANTEE.

14. ALL WORK WILL BE IN CONFORMANCE TO THE CITY OF HILLSBORO PUBLIC WORK'S DESIGN AND CONSTRUCTION STANDARDS (LATEST VERSION).

15. ALL FACILITIES INSTALLED UNDER THIS PERMIT SHALL BE FIELD LOCATED POST-CONSTRUCTION UTILIZING GNSS RECEIVERS AND ALL POSITIONS SHALL BE REPORTED WITH A RELATIVE ACCURACY OF 1.5 FEET.

**** NOTE ****
CONDUIT SHOULD BE PLACED IN THE PUE WHERE AVAILABLE

CAUTION!!!
CONTRACTOR TO LOCATE & VERIFY ALL EXISTING UTILITIES PRIOR TO CONSTRUCTION

**** NOTE ****
UTILITY & R.O.W. REPRESENTED ON PLANS ARE BASED ON RECORDS INFORMATION. NOT BASED ON BOUNDARY SURVEY & FIELD EXPOSURES.

**** NOTE ****
ALL CONDUIT TO BE PLACED AT 36" MINIMUM DEPTH UNLESS NOTED

0 30 60 120 FT

Magellan ADVISORS

General Notes

MAGELLAN ADVISORS

HIOBB LINK

TITLE: FIBER OPTIC CABLE ROUTE

FTTH OUTSIDE PLANT
UNDERGROUND ROW PERMIT/DESIGN
CITY OF HILLSBORO

DATE: 04/09/21
ENGINEER: SM
DRAWN BY: MA

REVISIONS

DATE	DESCRIPTION	INITIAL

HiLight

Oregon811 UTILITY NOTIFICATION CENTER

SCALE

HORIZONTAL:	1:640
VERTICAL:	1:640
MP	TO MP
SHEET	OF 138

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/21/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
KPD Insurance, Inc.
PO Box 784
Springfield OR 97477

CONTACT NAME:
PHONE (A/C, No, Ext): 541-741-0550 FAX (A/C, No): 541-741-1674
E-MAIL ADDRESS: wc-certs@kpdinsurance.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : SAIF Corp	36196
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED NORTELE02W
Northstar Electrical Contractors Inc.
11055 SW Clay Street
Sherwood OR 97140

COVERAGES **CERTIFICATE NUMBER:** 633017901 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N	N / A		793309	9/1/2021	9/1/2022	X PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBEREXCLUDED? ☐ (Mandatory in NH)						E.L. EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
RE: #2021-79 CBX Fiber WCCCA Connection - Contract #4629
* Additional Insured Does Not Apply to Workers' Compensation

CERTIFICATE HOLDER

Clackamas County
150 Beavercreek Road
Oregon City OR 97045

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Diana M Burnette

Evelyn Minor-Lawrence
Director

DEPARTMENT OF HUMAN RESOURCES

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

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

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

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

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

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

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

Sincerely,

Kristi Durham, Benefits Manager
Department of Human Resources

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

RECITALS

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

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

AMENDMENT

The Parties hereby agree as follows:

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

   "Clinical Claims Audit. *****

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

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

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

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

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

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

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

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

By: **Providence Health Plan**

Signature: Brad Garrigues

Name: Bradley J. Garrigues

Title: Chief Sales & Marketing Officer

Date: 10/14/21

By: **Clackamas County**

Signature: _____

Name: _____

Title: _____

Date: _____

EXHIBIT B: SERVICE FEES

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

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

EXHIBIT D: BUSINESS ASSOCIATE AGREEMENT

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

RECITALS

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

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

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

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

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

I. DEFINITIONS

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

II. OBLIGATIONS OF PROVIDENCE

1. Use and Disclosure of Health Information

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

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

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

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

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

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

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

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

2. Access to Books and Records

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

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

3. Access of Individuals to Information

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

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

4. Amendment of Information

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

5. Accounting for Disclosures of PHI

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

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

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

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

6. Disclosures to Third Parties

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

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

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

7. Breaches

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

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

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

8. Return/Destruction of Protected Health Information Upon Termination

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

III. OBLIGATIONS OF COVERED ENTITY

1. Use and Disclosure of PHI.

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

2. Covered Entity's Notice of Privacy Practices

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

3. Notification of Privacy Practices and Restrictions.

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

IV. TERM AND TERMINATION

1. General Term and Termination

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

2. Material Breach

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

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

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

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

3. Equitable Remedies

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

V. AMENDMENT

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

VI. INDEMNIFICATION

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

VII. COUNTERPARTS

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

VIII. CONFLICTING TERMS

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

IX. GOVERNING LAW

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

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

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

On behalf of itself and Covered Entity below:

- *Clackamas County Employee Flexible Benefit Plan*

EXHIBIT E-2: THIRD PARTY DISCLOSURE AGREEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

By 

Name Bradley J. Garrigues

Title Chief Sales & Marketing Officer

Date 10/14/21

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

By _____

Name _____

Title _____

Date _____

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

By 

Name Keith Storie

Title Principal

Date 10/19/2021

EXHIBIT E-3: THIRD PARTY DISCLOSURE AGREEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By Brad Garrigues

Name Bradley J. Garrigues

Title Chief Sales & Marketing Officer

Date 10/14/21

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

By _____

Name _____

Title _____

Date _____

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

By Mona Zielke

Name Mona Zielke

Title Vice President

Date 10/15/2021

2021 Summary Plan Description

Early Retirees – COBRA – Temporary Employees

Open Option

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

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

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Mail order prescription drug services	ProvidenceHealthPlan.com
Medical, Mental Health, and Chemical Dependency Prior Authorization Requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

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

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us," or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
  - Our Providence Signature Network of In-Network Providers;
  - Providence Health Plan's national network of In-Network Providers; and
  - Out-of-Network Providers.
- With this Plan, Members will generally have lower out-of-pocket expenses when obtaining Covered Services from In-Network Providers. Members may, however, obtain most Covered Services from Out-of-Network Providers, but that option will result in higher out-of-pocket expenses. Please see section 3 and your Plan Benefit Summary for additional information.
- Some Services are covered only under your In-Network benefits:
  - Web-direct Visits, as specified in section 4.3.2;
  - E-mail Visit Services, as specified in section 4.3.3;
  - Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7;
  - Tobacco Use Cessation Services, as specified in section 4.1.8;
  - Water births, as specified in section 4.8;
  - Human Organ/Tissue Transplant Services, as specified in section 4.13; and
  - Any item listed in your Benefit Summary as "Not Covered" Out-of-Network.
- Coverage is provided in full for most preventive Services when those Services are received from specified In-Network Providers. See your Benefit Summary for additional information.
- All Members are encouraged to choose a Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of In-Network Providers is available at ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in Plan documents. You should read the provisions, limitation and exclusions before seeking Covered Services because not all health care services are covered by this Plan.

- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

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

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

Your Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan allows you to receive Covered Services from In-Network Providers through what is called your In-Network benefit. You also have the option to receive most Covered Services from Out-of-Network Providers through what is called your Out-of-Network benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from In-Network Providers. Also, In-Network Providers will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services listed in section 3.5 are Prior Authorized by Providence Health Plan before treatment is received.

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

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

Whenever you visit a Provider:

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

2.2 SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains important information about the health plan coverage offered to employees of Clackamas County. It is important to read this Summary Plan Description carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 15. If you need additional help understanding anything in this Summary Plan Description, please call Customer Service at 503-574-7500 or 800-878-4445. *See section 2.3 for additional information on how to reach Customer Service.*

This Summary Plan Description is not complete without your:

- **Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, Copayments and Coinsurance for Covered Services and also provide other important information.
- **Provider Directory** which lists In-Network Providers, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

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

2.3 CUSTOMER SERVICE

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

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

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

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

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

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Summary Plan Description and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768

2.5 YOUR MEMBER ID CARD

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

- Your Member number and group number
- Important phone numbers

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

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

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

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

2.6 PROVIDENCE NURSE ADVICE LINE

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

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

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

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

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

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

Health Education

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

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

Health Coaching

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

Care Management

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

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

Tobacco Use Cessation

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

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

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

Wellness information on our website — www.ProvidenceHealthPlan.com

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

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

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

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

Assist America

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

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

Assist America also provides identity theft protection services for Providence Health Plan members. Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program. Please have your Providence Health Plan Member ID card ready, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

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

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

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

Appointment of Authorized Representative

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

Confidentiality and your Employer

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

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

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

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

3. HOW TO USE YOUR PLAN

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

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

3.1 IN-NETWORK PROVIDERS

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

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

3.1.1 Nationwide Network of In-Network Providers

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

3.1.2 Choosing an In-Network Provider

To choose an In-Network Provider, or to verify if a provider is an In-Network Provider, please refer to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

Advantages of Using an In-Network Provider

- Your In-Network Provider will work with Providence Health Plan to arrange for any Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.5.
- In most cases when you use In-Network Providers, higher benefit levels will apply and your out-of-pocket expenses will be reduced.
- You will have a wide variety of high quality In-Network Providers to help you with your health care needs.

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

3.1.3 Indian Health Services Providers

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

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

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

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

3.2.1 Primary Care Providers

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

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

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

3.2.2 Established Patients with Primary Care Providers

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

3.2.3 Selecting a New Primary Care Provider

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

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

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

3.2.4 Changing Your Primary Care Provider

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

3.2.5 Office Visits

Primary Care Providers

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

Specialists

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

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

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

Whenever you visit a specialist:

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

Alternative Care Providers

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

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

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

Benefits for Covered Services by an Out-of-Network Provider will be provided as shown in the Benefit Summary. See section 3.5 Prior Authorization requirements.

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

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If an Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

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

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

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

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

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

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

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

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

Payment for Covered Services Provided Before Disposition of Criminal Charges

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

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

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

3.4 NOTICE OF PROVIDER TERMINATION

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

3.5 PRIOR AUTHORIZATION

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

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

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

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

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

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

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

Prior Authorization Requests for Out-of-Network Services:
The Member or the Out-of-Network Provider must call us at 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:

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

Failure to Obtain Prior Authorization:
If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary.

3.6 TRAVEL EXPENSE REIMBURSEMENT

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

3.7 MEDICAL COST MANAGEMENT

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

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

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

A Substituted Services must:

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

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

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

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

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

3.7.1 Coverage of New Technology and New Application of Existing Technology

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

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

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

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

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

<u>Technology Evaluation Process</u>

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

<u>Expedited Review</u>

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

3.8 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.

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

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

3.9 APPROVED CLINICAL TRIALS

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

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

The following costs are excluded:

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

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

3.10 HOW BENEFITS ARE APPLIED

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

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

3.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

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

Deductible amounts apply to Out-of-Pocket Maximums.

3.11.1 Understanding Deductibles

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

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

Common In-Network and Out-of-Network Deductible: Your Plan has a **Common Deductible**, as listed in your Benefit Summary. **A Common Deductible applies to both In-Network and Out-of-Network benefits**. The Common Deductible can be met by using In-Network or Out-of-Network benefits, or a combination of both.

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

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

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

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

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

3.11.2 Understanding Out-of-Pocket Maximums

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

Common In-Network and Out-of-Network Out-of-Pocket Maximums: Your Plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum, as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Network and Out-of-Network benefits.

Individual Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100%* for Covered Services for that Member within that Calendar Year.

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

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

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

- Services not covered by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

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

4. COVERED SERVICES

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

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

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

4.1 PREVENTIVE SERVICES

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

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

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

4.1.1 Physical Examinations and Well-Baby Care

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

Recommended Guidelines:

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

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

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

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

4.1.2 Immunizations and Vaccinations

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

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members age 50 and older include:

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

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

For Members age 50 and older:

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

For Members under age 50:

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

4.1.5 Preventive Services for Members with Diabetes

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

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

4.1.6 Diabetes Self-Management Education Program

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

4.1.7 Nutritional Counseling

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

4.1.8 Tobacco Use Cessation Services

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

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

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

4.2.1 Gynecological Examinations

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

4.2.2 Mammograms

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

4.2.3 Breastfeeding Counseling and Support

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

4.2.4 Family Planning Services

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

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

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

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

- In-Network: Services are covered in full.

- Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g. IUDs and diaphragms are covered under your medical supply benefit.

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

4.3 PROVIDER SERVICES

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

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

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

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

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

4.3.2 Virtual Visits

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

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

4.3.3 E-mail Visits

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

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

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

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

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

4.3.4 Telemedical Services

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

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

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

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

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

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

4.3.6 Administration of Anesthesia and Surgical Procedures

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

4.3.7 Immediate Care

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

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

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

4.3.8 Retail Health Clinic

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.5.2 Emergency Medical Transportation

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

4.5.3 Emergency Eye Care Services

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

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the

onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

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

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

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

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

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

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

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

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

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

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

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

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

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

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

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

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

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

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

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

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

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

4.6.2 Skilled Nursing Facility

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

4.6.3 Inpatient Rehabilitative Care

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

4.6.4 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

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

4.7 OUTPATIENT SERVICES

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

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

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

4.7.2 Outpatient Rehabilitative Services

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

Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). All Services are subject to review for Medical Necessity. Limits do not apply to Mental Health Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.)

Covered Services under this benefit do NOT include:

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

4.7.3 Outpatient Habilitative Services

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

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

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

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

Covered Services include:

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

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

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

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

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

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

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

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

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

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

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

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

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

4.9.1 Medical Supplies (including Diabetes Supplies)

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

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

4.9.2 Medical Appliances

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

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

4.9.3 Prosthetic and Orthotic Devices

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

4.9.4 Durable Medical Equipment (DME)

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

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

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

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

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

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

4.10.2 Applied Behavior Analysis

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

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

Exclusions to ABA Services:

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

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

4.10.3 Substance Abuse Services

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

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

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

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

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

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

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

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

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency. If you were hospitalized immediately prior to the commencement of home health care, the home health care plan must be initially approved by the Qualified Practitioner who was the primary provider of Services during the hospitalization.

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

Home health care benefits do NOT include:

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

4.11.2 Hospice Care

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

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

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

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

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

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

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

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

4.12.2 Inborn Errors of Metabolism

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

4.12.3 Podiatry/Foot Services

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

4.12.4 Reconstructive Surgery

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

4.12.5 Reconstructive Breast Surgery

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

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

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

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

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

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

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

Exclusions that apply to Covered Services include:

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

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

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

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

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

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

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic X-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 4.9.2(Medical Appliances). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and
6. Surgical Services.

TMJ Services are covered as shown in your Benefit Summary; limits may apply.

Out-of-Network benefits do not apply to TMJ Services.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

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

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

4.12.9 Chiropractic Manipulation

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

4.12.10 Acupuncture

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

4.12.11 Gender Dysphoria

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

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

4.12.12 Elective Sterilization

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

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

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

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

4.12.13 Hearing Loss Services

Definitions:

Cochlear Implant

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

Hearing Aid

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

Covered Services:

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

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

Cochlear implants:

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

Hearing aids & related accessories:

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

Diagnostic & Treatment Services:

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

Hearing Assistance Technology:

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

Limits to Hearing Loss Services

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

4.12.14 Wigs

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

4.12.15 Biofeedback

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

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

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

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

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

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

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel expenses are not covered for donors.)

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

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

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

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

4.13.3 Benefits for Outpatient Medications

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

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

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

4.13.5 Transplant Prior Authorization

(See also section 3.5.)

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

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

4.13.6 Transplant Exclusions

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

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

4.14 PRESCRIPTION DRUG BENEFIT

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

Prescription Drug Definition

The following are considered "Prescription Drugs":

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

4.14.1 Using Your Prescription Drug Benefit

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

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

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

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

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

- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drugs at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at www.ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies.)
- Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances and Deductibles.

4.14.2 Use of Out-of-Network Pharmacies

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

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

Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-. Submission of a claim does not guarantee payment.

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

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

4.14.3 Prescription Drug Formulary

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

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

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

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

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

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

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

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

Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

Affordable Care Act Preventive Drugs

Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our Formulary and are covered at no cost when received from Participating Pharmacies as required by the ACA. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. However, over-the-counter contraceptives do not require a written prescription pursuant to Oregon state law.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

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

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

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

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

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

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

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety

and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.

2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.
7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.
8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug Exclusions

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

1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 16 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Over-the-counter (OTC) drugs or vitamins that may be purchased without a provider's written prescription, except as required by federal or Oregon state law;
9. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
10. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions or as required by federal or Oregon state law;
11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (*e.g.,* gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.

4.14.9 Prescription Drug Disclaimer

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

5. EXCLUSIONS

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

General Exclusions:

The Plan does not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition);

The Plan does not cover:

- Charges that are in excess of the Usual, Customary, and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as provided in section 4.3.2
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.6 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 4.12.15;
- Massage therapy;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.9 and 4.12.10;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; and

- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2.
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice.
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;
- Recreation services, therapeutic foster care, wraparound services, emergency aid for household items and expenses; services to improve economic stability, and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;

- All services related to artificial insemination, including charges for semen harvesting and storage;
- All services and prescription drugs related to fertility preservation;
- Diagnostic testing and associated office visits to determine the cause of infertility;
- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
  - Physical examination;
  - Related laboratory testing;
  - Instruction;
  - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
  - Related supplies and prescriptions.

For the purpose of this exclusion:

- Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
- Artificial reproduction means the creation of new life other than by the natural means.

- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.1.9, 4.5.3 and 4.9.2;
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.13.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth; dental implants), except as approved by us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

6. CLAIMS ADMINISTRATION

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

6.1 CLAIMS PAYMENT

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

Explanation of Benefits (EOB)

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

Time Frames for Processing Claims

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

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

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

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

Claims Involving Concurrent Care Decisions. If an ongoing course of treatment for you has been approved under the Plan and it is determined through Concurrent Review procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request a reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. You will then be notified of Providence Health Plan's reconsideration decision within 24 hours after your request is received.

6.1.1 Timely Submission of Claims

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

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

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

6.1.2 Right of Recovery

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

6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and

may reduce the benefits payable so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

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

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

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

Closed panel plan

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

Custodial parent

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

6.2.2 Order of Benefit Determination Rules

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

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

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

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

coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

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

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- The Plan covering the Dependent spouse of the non-custodial parent, last.

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

d) For a Dependent child:

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

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

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

agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

6.2.3 Effect on the Benefits of This Plan

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

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

6.2.4 Right to Receive and Release Needed Information

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

6.2.5 Facility of Payment

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

6.2.6 Right of Recovery

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

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

6.2.7 Coordination with Medicare

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

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

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

Counting individuals for the Employer size:

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

6.3 THIRD-PARTY LIABILITY/SUBROGATION

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

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

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the Plan or the Member. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member's heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any

person or for which the Member or the Member's heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, the Plan will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Plan.

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

"Subrogation" means that the Plan may collect directly from the third party to the extent the Plan has paid for third-party liabilities. Because the Plan has paid for the Member's injuries, the Plan, rather than the Member, is entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify the Plan in writing of any terms or conditions offered in settlement and must notify the third party of the Plan's interest in the settlement established by this provision.

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

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

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason the Plan is not paid directly by the third party, the Plan is entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and the Plan may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by the Plan, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, the Plan is entitled to the proceeds whether or not the loss is deemed to be compensable under the workers'

compensation laws. The Plan is entitled to recover up to the full value of the benefits provided by the Plan for the condition, calculated using the Plan's UCR charges for such Services, less the Plan's pro-rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. The Plan is entitled to first priority in repayment, over the Member and over any other person, for such charges.

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

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

6.3.3 Suspension of Benefits and Reimbursement

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

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

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

6.3.4 Special Rules for Motor Vehicle Accident Cases

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

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

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

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

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

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

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

Appeal

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

Authorized Representative

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

Concurrent Care

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

Grievance

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

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

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

7.2.1 Your Grievance and Appeal Rights

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

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

Request for Claim/Appeal File and Additional Information:

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

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

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

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

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

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

7.2.2 Internal Grievance or Appeal

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

7.2.3 External Review

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

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

The Plan pays for all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of

the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

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

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

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

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. ELIGIBILITY AND ENROLLMENT

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

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

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

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

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

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and
b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and
c) Such coverage:
    - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
    - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
        1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or

2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or
3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New Dependents

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

The "special enrollment period" shall be a period of 60 days and begins on the later of:

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

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

If you or your Eligible Family Dependent were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent

becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children's Health Insurance Program (CHIP)-sponsored arrangement, the Plan will provide a "special enrollment period" for you and your Family Member(s) if you request enrollment within 60 days after the date of entitlement.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

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

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

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

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

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

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

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

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

10. CONTINUATION OF GROUP MEDICAL BENEFITS

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

10.1 COBRA CONTINUATION COVERAGE

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

10.1.1 Subscriber's Continuation Coverage

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

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

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

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

10.1.3 Dependent's Continuation Coverage

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

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

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

10.1.4 Notice Requirements

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

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

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 COBRA Premiums

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

10.1.8 Length of COBRA Continuation Coverage

18-Month Continuation Period

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

29-Month Continuation Period

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

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

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

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

36-Month Continuation Period

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

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

10.1.9 Extension of Continuation Period

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

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

10.1.10 Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the Pension Benefit Guaranty Corporation (PBGC), to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of sixty-five percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax

Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY caller may call toll-free at 866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

10.1.11 When COBRA Continuation Coverage Ends

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

- Clackamas County no longer provides health coverage to any employees;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary (employee, spouse or dependent child) later becomes covered under another health plan;
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

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

11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS)

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

As a participant in Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, provided you request it in writing and reasonably describe the information.
    - You may obtain copies, subject to paying a reasonable copying charge.
    - You are entitled to know to whom we may have disclosed any such information.
    - You are entitled to correct any errors in the information.

2. Continue group health coverage
    - Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.1.
3. Enforce your rights

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

    As more fully described in section 7, the Plan offers a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (IRO) decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2.

    Member's sole right of Appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between the Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

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

12.1 DEFINITIONS

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

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

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

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

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

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

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

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

12.2 NOTICE UPON RECEIPT OF ORDER

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

12.3 NOTICE OF DETERMINATION

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

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

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

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

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

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

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

12.5 COST OF COVERAGE

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

12.6 REIMBURSEMENT OF PLAN EXPENSES

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

12.7 STATUS OF ALTERNATE RECIPIENT

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

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

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

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

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

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

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

13. GENERAL PROVISIONS

13.1 CONFLICTS OF PROVISIONS

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

13.2 CONTROLLING STATE LAW

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

13.3 DUPLICATING PROVISIONS

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

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 GENDER AND NUMBER

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

13.6 HEADINGS

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

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2. If ERISA does not apply (see section 11.2) the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND PROVISIONS

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

13.9 MEMBER RESPONSIBILITY

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

13.10 MEMBERSHIP ID CARD

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

13.11 NON-TRANSFERABILITY OF BENEFITS

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

13.12 NO GUARANTEE OF EMPLOYMENT

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

13.13 NO RECOURSE FOR ACTS OF PROVIDERS

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

13.14 NON-WAIVER

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

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Providence Health Plan, P.O. Box 3125, Portland, OR 97208.

13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly by an Out-of-Network Provider and you pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to Providence Health Plan of the payment. Payment will be made to the Member, subject to written notice of claim, or, if deceased, to the Member's estate, unless payment to other parties is authorized in writing by you. See section 6.1.1 regarding timely submission of claims.

13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

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

13.18 PHYSICAL EXAMINATION AND AUTOPSY

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

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

13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

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

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

13.20 REQUIRED INFORMATION TO BE FURNISHED

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

13.21 RIGHT OF RECOVERY

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

13.22 SEVERABILITY

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

13.23 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

- Payment for benefits with respect to a Member under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Member, as required by a State Medicaid Plan;

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

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

13.24 SUGGESTIONS

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

13.25 VETERANS' RIGHTS

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

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

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 TYPE OF ADMINISTRATION

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

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

14.2 PLAN INFORMATION

Plan Name: Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The effective date of the Plan is January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

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

14.7.1 Complete Allocation of Fiduciary Responsibilities

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

14.8 ENGAGEMENT OF ADVISORS

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

14.9 INDEMNIFICATION

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

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

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

14.10.2 Manner of Action

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

14.10.3 Effect on Benefits

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

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

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

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

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

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

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

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

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

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

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

14.11.2 Security

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

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

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

Adverse Benefit Determination
See section 7.

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

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

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

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

Authorized Representative
See section 7.

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

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

Chemical Dependency
Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Substance Abuse does not mean an addiction to, or dependency on tobacco, tobacco products or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan
Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant
See section 4.12.13.

Coinsurance
Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

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

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

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

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

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

Covered Service
Covered Service means a Service that is:

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

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care

Custodial Care means Services that:

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

Such Services will still be considered Custodial Care even if:

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

Deductible

See section 3.11.1.

Dependent

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

Domestic Partner

A Domestic Partner means either of the following:

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

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

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

Durable Medical Equipment (DME)
Durable Medical Equipment means equipment that must:
1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

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

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

Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee
Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.
1. Employment Status: On-call, substitute, and seasonal employees are not eligible.
2. Employment Category/Class: Non-Medicare Early Retiree-COBRA-Temporary Employees.
3. Work Hours: Not applicable for Early Retirees or COBRA participants. Temporary Employees: work an average of 30 or more hours during the most recent Affordable Care Act measurement period or are hired with the intent of working more than an average of 30 hours per week for longer than 90 days.
4. Eligibility Waiting Period: Not applicable for Early Retirees or COBRA participants. Temporary Employees: minimum of 60 days.*
   (*Note: Effective July 1, 2021, the Eligibility Waiting Period for Temporary Employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: COBRA: first day following loss of Active coverage. Early Retiree: first of the month following retirement. Temporary Employees: the first day of

the month following completion of the Eligibility Waiting Period if working 30 or more hours per week or on January 1 if they met the definition of fulltime under the Affordable Care Act during the most recent measurement period.

6. Location: Not applicable for Early Retirees and COBRA participants.
7. Leave of Absence Status: Not applicable for Early Retirees and COBRA participants. Temporary Employees: An otherwise eligible Temporary Employee on an Employer-approved Leave of Absence shall remain eligible during the first 6 months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: Not applicable.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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

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

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

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

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

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

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

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

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

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

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

- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

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

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

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

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

Hearing Aid
See section 4.12.13.

Hearing Assistance Technology
See section 4.12.13.

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

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

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

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

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

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

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

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

Late Enrollee
Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

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

The criteria are based on the following principles:

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

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

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

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

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

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

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

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

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

Out-of-Pocket Maximum
See section 3.11.2.

Outpatient Surgical Facility

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

Participating Pharmacy

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

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

Plan

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

Plan Administrator

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

Plan Year

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

Primary Care Provider

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

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

Prior Authorization

Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.5. Prior Authorized determinations are not a guarantee of benefit payment unless:

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

Providence Health Plan

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

Qualified Practitioner

Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, naturopath, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility

Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery

Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic

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

Service

Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

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

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

Subscriber
Subscriber means an employee or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

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

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

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

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

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

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

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;

4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

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

Virtual Visit
Virtual Visit means a visit with a Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network or Out-of-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

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

16. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

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

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

Language Access Information

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

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

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

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

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

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

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

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

لحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا. اتصل بالرقم 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 می‌کنید، تسهیلات زبانی 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 Early Retiree-COBRA-Temporary Employees Open Option Plan. This document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan

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

Conformity with Law

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

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed, effective as of January 1, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

1

Our Mission

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

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); or one of our Sales representatives at 503-574-6300 or 877-245-4077, 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

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

2021 Summary Plan Description

General County Employees

Open Option

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 Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Mail order prescription drug services	ProvidenceHealthPlan.com
Medical, Mental Health, and Chemical Dependency Prior Authorization Requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us," or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
  - Our Providence Signature Network of In-Network Providers;
  - Providence Health Plan's national network of In-Network Providers; and
  - Out-of-Network Providers.
- With this Plan, Members will generally have lower out-of-pocket expenses when obtaining Covered Services from In-Network Providers. Members may, however, obtain most Covered Services from Out-of-Network Providers, but that option will result in higher out-of-pocket expenses. Please see section 3 and your Plan Benefit Summary for additional information.
- Some Services are covered only under your In-Network benefits:
  - Web-direct Visits, as specified in section 4.3.2;
  - E-mail Visit Services, as specified in section 4.3.3;
  - Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7;
  - Tobacco Use Cessation Services, as specified in section 4.1.8;
  - Water births, as specified in section 4.8;
  - Human Organ/Tissue Transplant Services, as specified in section 4.13; and
  - Any item listed in your Benefit Summary as "Not Covered" Out-of-Network.
- Coverage is provided in full for most preventive Services when those Services are received from specified In-Network Providers. See your Benefit Summary for additional information.
- All Members are encouraged to choose a Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of In-Network Providers is available at ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations, and exclusions that are specified in Plan documents. You should read the provisions, limitation, and exclusions before seeking Covered Services because not all health care services are covered by this Plan.

- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

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

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN

Your Plan allows you to receive Covered Services from In-Network Providers through what is called your In-Network benefit. You also have the option to receive most Covered Services from Out-of-Network Providers through what is called your Out-of-Network benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from In-Network Providers. Also, In-Network Providers will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-In-Network Providers, it is your responsibility to make sure the Services listed in section 3.5 are Prior Authorized by Providence Health Plan before treatment is received.

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

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

Whenever you visit a Provider:

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

2.2 SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains important information about the health plan coverage offered to employees of Clackamas County. It is important to read this Summary Plan Description carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 15. If you need additional help understanding anything in this Summary Plan Description, please call Customer Service at 503-574-7500 or 800-878-4445. *See section 2.3 for additional information on how to reach Customer Service.*

This Summary Plan Description is not complete without your:

- **Clackamas County General County Open Option Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, Copayments, and Coinsurance for Covered Services and also provide other important information.
- **Provider Directory** which lists In-Network Providers, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

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

2.3 CUSTOMER SERVICE

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

- Specific benefit or claim questions.
- Questions or concerns about your health care or service.

Contacting Providence Customer Service
Customer Service representatives are available by phone from 8 a.m. to 5 p.m., Monday through Friday, (excluding holidays). **Please have your Member ID Card available when you call:**

- **Members in the Portland-metro area, please call 503-574-7500.**
- **Members in all other areas, please call toll-free 800-878-4445.**
- **Members with hearing impairment, please call the TTY line 711**

You may **access claims and benefit information 24 hours a day, seven days a week** online through your myProvidence account.

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Summary Plan Description and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768.

2.5 YOUR MEMBER ID CARD

Each Member of Providence Health Plan receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member number and group number
- Important phone numbers

The Member ID Card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your Member ID Card, and pay your Copayment or Coinsurance.

Please keep your Member ID Card with you and use it when you:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse Customer Service.
- Call or correspond with Customer Service.
- Call Providence nurse advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.

2.6 PROVIDENCE NURSE ADVICE LINE

503-574-6520; toll-free 800-700-0481; TTY 711

The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6, for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching
Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence, and behavioral patterns. (See section 4.1.8 regarding coverage for Tobacco Use Cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

Quit for Life can be reached at 866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts, and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account*, section 2.4, for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America

Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services for Providence Health Plan members. Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program. Please have your Providence Health Plan Member ID card ready, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information," we mean information that identifies you as an individual (such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain their medical records from their provider. Call your physician's or provider's office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represent a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan.

Providence Health Plan may disclose a Member's PHI to an employer or any agent of the Employer if the disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it.

3. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Primary Care Provider, who can provide most of your care, suggest specialist care, and arrange for Hospital care or diagnostic testing.

This section describes how to use this Plan and how benefits are applied. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered using your In-Network benefit, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is an In-Network Provider even if you have been directed or referred for care by an In-Network Provider.

3.1.1 Nationwide Network of In-Network Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services when using In-Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing an In-Network Provider

To choose an In-Network Provider, or to verify if a provider is an In-Network Provider, please refer to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

Advantages of Using an In-Network Provider

- Your In-Network Provider will work with Providence Health Plan to arrange for any Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.5.
- In most cases when you use In-Network Providers, higher benefit levels will apply and your out-of-pocket expenses will be reduced.
- You will have a wide variety of high quality In-Network Providers to help you with your health care needs.

So remember, it is to your advantage to meet your health care needs by using an In-Network Provider, including an In-Network Primary Care Provider, whenever possible.

3.1.3 Indian Health Services Providers

Native American Indian and Alaskan Native Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from an In-Network Provider. For a list of IHS facilities, please visit the IHS website at www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend that upon joining Providence Health Plan you and each of your Family Members choose an In-Network Primary Care Provider as soon as possible.

3.2.1 Primary Care Providers

A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider.

Primary Care Providers provide preventive care and health screenings, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Primary Care Providers offer maternity care and minor outpatient surgery as well.

IMPORTANT NOTE: In-Network Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our In-Network Providers with the specialties listed above are In-Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated In-Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend that you choose a Primary Care Provider from our Provider Directory, available online, for each covered Family Member. Call the provider's office to make sure they are accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

- What are the office hours?
- How can I get medical advice after hours?
- What do I do in an emergency?

Let your Primary Care Provider know if you are under a specialist's care as well as if you are currently taking any ongoing prescription medications.

3.2.4 Changing Your Primary Care Provider

You are encouraged to establish an ongoing relationship with your Primary Care Provider. If you decide to change your Primary Care Provider, please remember to have your medical records transferred to your new Primary Care Provider.

3.2.5 Office Visits

Primary Care Providers

We recommend you see your Primary Care Provider for all routine care and call your Primary Care Provider first for urgent or specialty care. If you need medical care when your Primary Care Provider is not available, the physician/provider on call may treat you and/or recommend that you see another provider for treatment.

Specialists

Your Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a specialist for treatment.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who is an In-Network Provider with Providence Health Plan.

If you decide to see a specialist on your own, we recommend you let your Primary Care Provider know about your decision. Your Primary Care Provider will then be able to coordinate your care and share important medical information with your specialist. In addition, we recommend you let your specialist know the name and contact information of your Primary Care Provider.

Whenever you visit a specialist:

- Bring your Providence Health Plan Member ID Card.
- Understand that in most cases, your out-of-pocket costs will be a percent of the charges for services. Your provider's office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and will bill or credit you the balance later. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Alternative Care Providers

This Plan includes coverage for office visits to alternative care providers as listed in your Benefit Summary. See section 15 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.9, 4.12.10 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

As a Member of this Plan, you may choose to receive Covered Services from Out-of-Network Qualified Practitioners and facilities using your Out-of-Network benefit.

Benefits for Covered Services by an Out-of-Network Provider will be provided as shown in the Benefit Summary. (See section 3.5 for Prior Authorization requirements.)

Generally, when you receive Services from Out-of-Network Providers, your Copayments and Coinsurance will be higher than when you see In-Network Providers.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If an Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an Out-of-Network Provider, those Services are still subject to the terms of this Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

If the provider you choose is Out-of-Network, it is important for you to understand that Providence Health Plan has not assessed the provider's credentials or quality; nor has Providence Health Plan reviewed and verified the Out-of-Network Provider's qualifications and history for information such as: relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Additionally, the Out-of-Network Provider will not have been assessed by Providence Health Plan to verify that the provider meets certain criteria relating to professional competence and conduct and as such is not guaranteed to follow your benefit plan, rules, regulations, or guidelines with regard to standards of care nor standards of documentation and billing.

Some Services are only covered under your In-Network benefit:

- Web-direct Visits (see section 4.3.2).
- E-mail Visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Retail Health Clinic Visits (see section 4.3.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network.

Payment for Out-of-Network Physician/Provider Services (UCR)

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Network benefits as shown in the following example (amounts shown are only estimates of what may apply).

	Provider's Status	
Item	In-Network	Out-of-Network
Provider's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount that the provider may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.

Payment for Covered Services Provided Before Disposition of Criminal Charges

If you are in the custody of an Oregon state or local corrections agency pending the disposition of criminal charges brought by an Oregon county, we will reimburse the custodial county for the costs of Covered Services or supplies rendered before the disposition of charges, in an amount that is no less than 115 percent of the Medicare rate for the service or supply, except for renal dialysis which will be reimbursed in accordance with the terms of the Plan for Out-of-Network dialysis providers.

The following Services and Supplies are excluded from coverage under this section:

- Diagnostic tests or health evaluations required by the corrections agency, as a matter of course, for all individuals who are in the custody of the county pending the disposition of charges;
- Hospital and ambulatory surgical center services, except as rendered by an In-Network provider.

3.4 NOTICE OF PROVIDER TERMINATION

When an In-Network Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within 10 days of the termination date or of our knowledge of the termination date.

3.5 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from In-Network Providers:
When Services are received from an In-Network Provider, the In-Network Provider is responsible for obtaining Prior Authorization.

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.6.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.3.
- All Applied Behavior Analysis, as provided in section 4.10.2.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1;
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.

- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.
- Certain medications, including certain immunizations, received in your Provider's office, as provided in sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

Providence Health Plan will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call Customer Service at the number listed on your Member ID Card.

If an Emergency Medical Condition exists which prevents you from obtaining Prior Authorization, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

Prior Authorization Requests for Out-of-Network Services:
The Member or the Out-of-Network Provider must call us at 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:

- The Member's name and date of birth.
- The Member's Providence Health Plan Member number and Group number (these are listed on your Member ID card).
- The Provider's name, address, and telephone number.
- The name of the Hospital or treatment facility.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

Failure to Obtain Prior Authorization:
If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary.

3.6 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.7 MEDICAL COST MANAGEMENT

Coverage under this Plan is subject to the medical cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

The Plan reserves the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by Providence Health Plan. When more than one medically appropriate alternative is available, Providence Health Plan will approve the least costly alternative.

In accordance with Providence Health Plan's medical cost management protocols and criteria specified in this paragraph, Providence Health Plan may approve substitutions for Covered Services under this Plan.

A Substituted Services must:

1. Be Medically Necessary;
2. Have your knowledge and agreement while receiving the Service;
3. Be prescribed and approved by your Qualified Practitioner; and
4. Offer a medically therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

The Plan's coverage of a Substituted Service for any Member does not obligate the Plan to:

- Cover a Substituted Service for any other Member;
- Continue to cover a Substituted Service beyond the term of the agreement between the Plan and the Member; or
- Cover any Substituted Service for the Member, other than as specified in the agreement between the Plan and the member.

Substituted Services that satisfy the requirements of this section are Covered Services for all purposes under this Plan.

A Substituted Service may be disallowed at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.

3.7.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

Providence Health Plan has developed standards to guide the evaluation process and to ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage:

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

A committee of medical directors with physician specialist advisors evaluates all new technology and determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services that provide independent analysis of a new technology.

Expedited Review

Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 7.

3.8 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees

of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.

- ***Example:*** *Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.*
- ***Example:*** *You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor's office. The Plan would not pay for that visit.*
- ***Example:*** *You stay an extra day in the hospital only because the relative who will help you during recovery cannot pick you up until the next morning. We may not pay for the extra day.*

Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.9 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial. If your Approved Clinical Trial is available through both Network and Out-of-Network providers, the Plan will require you to participate through an In-Network Provider.

Covered Services include the routine patient costs for items and services received in connection with the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services under the Plan.

The following costs are excluded:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for services unrelated to a clinical trial to the extent that the services are otherwise Covered Services under the Plan.

3.10 HOW BENEFITS ARE APPLIED

Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:

1. The Deductible;
2. The Copayment or Coinsurance amount; and
3. The benefit limits and/or maximums.

3.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Your Plan has a Deductible and an Out-of-Pocket Maximum, as stated in your Benefit Summary.

Deductible amounts apply to Out-of-Pocket Maximums.

3.11.1 Understanding Deductibles

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year when receiving most Covered Services before benefits are provided by us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

Certain Covered Services, such as most In-Network preventive care, are covered without a Deductible. Please see your Benefit Summary for information about these Services.

Common In-Network and Out-of-Network Deductible: Your Plan has a **Common Deductible**, as listed in your Benefit Summary. **A Common Deductible applies to both In-Network and Out-of-Network benefits**. The Common Deductible can be met by using In-Network or Out-of-Network benefits, or a combination of both.

Individual Deductible: An Individual Deductible is the amount shown in the Benefit Summary that must be paid by a Member before the Plan provides benefits for Covered Services for that Member.

Family Deductible: The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this Plan, and is the maximum Deductible that enrolled Family Members must pay. All amounts paid by Family Members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled Family Members.

Note: No Member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services for that Member.

Your Costs that Do Not Apply to Deductibles: **The following out-of-pocket costs do not apply towards Your Individual and Family Deductibles:**

- Services not covered by this Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

3.11.2 Understanding Out-of-Pocket Maximums

Out-of-Pocket Maximums are the total amount you will pay out-of-pocket in any Calendar Year for Covered Services received under this Plan. See your Benefit Summary.

Common In-Network and Out-of-Network Out-of-Pocket Maximums: Your Plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum, as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Network and Out-of-Network benefits.

Individual Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

Family Out-of-Pocket Maximum: Family Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a family of two or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment, Coinsurance and Deductible expenses of enrolled Family Members meet the family Out-of-Pocket Maximum, all remaining individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Note: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

Your Costs that Do Not Apply to Out-of-Pocket Maximums: **The following out-of-pocket costs do not apply toward your Individual and Family Out-of-Pocket Maximums:**

- Services not covered by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

IMPORTANT NOTE: Some Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services, as shown in the Benefit Summary, remains in effect throughout the Calendar Year.

4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

Benefits are provided for preventive care and for the treatment of illness or injury when such treatment is Medically Necessary and provided by a Qualified Practitioner as described in this section and shown in the Benefit Summary.

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4. 2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, http://www.hrsa.gov/womens-guidelines.

Note: Additional Plan provisions apply to some Services (e.g., to be covered in full, routine physical examinations and well-baby care must be received from an In-Network Provider, see section 4.1.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination, and as indicated in section 4.1.9. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

Infants up to 30 months:	Up to 12 well-baby visits.
Children and Adolescents:	
3 years through 21 years:	One exam every year.
Adults:	
22 years through 29 years:	One exam every five years.
30 years through 49 years:	One exam every two years.
50 years and older:	One exam every year.

If, at the time of your routine physical examination or well-child care, you need paperwork completed for a third party, such as school, camp, team sports, etc., your provider may charge you a fee to complete the paperwork. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.14.

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.

4.1.3 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by your Qualified Practitioner for men designated as high risk.

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations include:

- One fecal occult blood test per year, plus one sigmoidoscopy every five years; or
- One colonoscopy every 10 years; or
- One double contrast barium enema every five years.

Screening examinations and lab tests for Members designated as high risk are covered as recommended by your Qualified Practitioner.

- In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our Formulary.
- Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit.

4.1.5 Preventive Services for Members with Diabetes

Preventive Covered Services for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- A dilated retinal exam by a qualified eye care specialist every Calendar Year;
- A glycosylated hemoglobin (HbA1c) test, a urine test to test kidney function, blood test for lipid levels as appropriate, a visual exam of mouth and teeth (dental visits are not covered), foot inspection, and influenza vaccine by a Qualified Practitioner every Calendar Year; and
- A pneumococcal vaccine every five years.

4.1.6 Diabetes Self-Management Education Program

Benefits are paid in-full for diabetes self-management education programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes as prescribed by a Qualified Practitioner. “Diabetes self-management program” means one program of assessment and training after diagnosis as well as assessment and training upon a material change of condition, medication or treatment. All services must be received from licensed providers and facilities, practicing within scope of license.

4.1.7 Nutritional Counseling

Nutritional counseling is covered when Medically Necessary, as shown in your Benefit Summary. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services

Coverage is provided for participation in a Providence Health Plan-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. “Tobacco use cessation program” includes educational and medical treatment components such as, but not limited to, counseling, classes, nicotine replacement therapy, and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of Providence Health Plan-approved programs is available online at www.ProvidenceHealthPlan.com (select “search” and enter “tobacco cessation”) or by calling Customer Service at 503-574-7500 or 800-878-4445.

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

4.2.1 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and Pap examinations once every Calendar Year or more frequently for women who are designated high risk. Family planning Services are separate (see section 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider.

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Lactation Counseling Services must be received from licensed providers. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through Network Medical Equipment Providers. Out-of-Network, coverage is subject to your Durable Medical Equipment (DME) benefits.

4.2.4 Family Planning Services

Benefits include counseling, exams, and services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Network Pharmacy.

All Covered Services must be received from Qualified Practitioners and Facilities or purchased from Participating Pharmacies.

- In-Network: Services are covered in full.

- Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g. IUDs and diaphragms are covered under your medical supply benefit.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.13.

4.3 PROVIDER SERVICES

4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Some services provided by your Qualified Practitioner during your visit may result in additional Member financial responsibility.

For example – You see your Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific services, such as allergy shots, maternity care, and diagnostic services. See your Benefit Summary for details.

If you are unable to keep a scheduled office appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Providence Health Plan will not cover this expense.

4.3.2 Virtual Visits

The Plan provides coverage for Virtual Visits using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and may be received from authorized In-Network or Out-of-Network Providers. Not all Providers are contracted with us to provide Phone and Video Visits. Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.
- Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers who may be approved for E-mail Visits. In-Network Providers who are authorized to provide E-mail Visits have agreed to use Internet security technology approved by us to protect your information from unauthorized access or release. To be eligible for the E-mail Visit benefit, you must have had at least one prior office visit with your In-Network Provider within the last 12 months.

Covered E-mail Visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by the Plan;
- Communications by the In-Network Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of e-mail communications that do not qualify as E-mail Visits include, but are not limited to:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
- All communications in connection with Mental Health or Substance Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service:

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and

- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site.

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

4.3.7 Immediate Care

Immediate Care is an extension of your Primary Care Provider's office, and provides additional access to treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Immediate Care Provider.

4.3.8 Retail Health Clinics

Coverage is provided as shown in the Benefit Summary for Covered Services obtained at Retail Health Clinics. Retail Health Clinics can provide diagnosis and treatment services for uncomplicated minor illnesses and injuries, like sore throats, ear aches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

4.4 DIAGNOSTIC SERVICES

Coverage is provided as shown in your Benefit Summary for Diagnostic Services.

4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

4.4.2 Sleep Study Services

Benefits are as shown in the Benefit Summary and include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

Benefits for Emergency Care and Urgent Care Services are provided as described below and shown in your Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

4.5.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Medically necessary detoxification
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Unexpected premature childbirth

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency

Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:
"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part;
- Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child; or
- That is a behavioral health crisis.

"*Emergency Services"* means, with respect to an Emergency Medical Condition:

- An Emergency Medical Screening Exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"*Emergency Medical Screening Exams"* include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card.

Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care.

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit.

If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits.

Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 3.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

4.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary emergency care or to a facility specified by Providence Health Plan. Air ambulance transportation is only covered for a life-threatening medical emergency, or when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time. Ambulance transportation solely for personal comfort or convenience is not covered.

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions resulting from an injury to or illness of the eye(s). Members may receive Services directly from an optometrist or ophthalmologist or from a Hospital emergency room.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the

onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their office is not Urgent Care.

Whenever you need urgent care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Qualified Provider.

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

When you are admitted to an Out-of-Network Hospital from an Urgent Care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits.

Not all Out-of-Network facilities will file a claim on a Member's behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services.

Covered Services do NOT include care received that consists primarily of:

- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.

- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases, the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

- Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

In-Network Benefit: When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital.

Out-of-Network Benefit: You are responsible for making sure inpatient hospitalization services are Prior Authorized by Providence Health Plan before receiving this care from an Out-of-Network Hospital.

Only Medically Necessary hospital services are covered. Covered inpatient Services received in a Hospital are:

- Acute (inpatient) care;
- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care, and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by Providence Health Plan and prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary.

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.2 for coverage of Outpatient Rehabilitative Services.)

4.6.4 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24 - 48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider’s office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5.

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). All Services are subject to review for Medical Necessity. Limits do not apply to Mental Health Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.)

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Deductible, Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits, and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

Covered Services include:

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care*.
- Newborn nurse home visits**.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit.

**Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services.

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

The services of a lay, unlicensed direct entry, certified professional, or any other unlicensed midwife are not covered.

Water births, regardless of location, will only be covered when performed by a licensed In Network Provider. No coverage will be provided for water births performed by Out of Network Providers.

Length of maternity hospital stay: Your services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery, and a minimum of 96 hours for a Caesarean delivery. You will not be discharged from the hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

Maternity support services: Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

Diabetes coverage during pregnancy: During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Network.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES, AND DURABLE MEDICAL EQUIPMENT (DME)

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) are provided as shown in the Benefit Summary when required for the standard treatment of illness of injury. Providence Health Plan may authorize the purchase of an item if they determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by a Qualified Practitioner.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or more efficient model are not covered unless Medically Necessary. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.

4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan Network medical supply providers or under this benefit at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

Benefits are provided as shown in the Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances, including Hearing Aids and Hearing Assistance Technology (HAT), as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck; or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 4.9.2).

4.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by Providence Health Plan.

Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.5.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program;
- Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and

- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

An approved ABA treatment plan is subject to review by us, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

4.10.3 Substance Abuse Services

Benefits are provided for Substance Abuse Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan.

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.5.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and are described below. The Plan will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Plan.

Any visit by a person providing Services under a home health care plan, or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency. If you were hospitalized immediately prior to the commencement of home health care, the home health care plan

must be initially approved by the Qualified Practitioner who was the primary provider of Services during the hospitalization.

If the above criteria are not met, NO benefits will be provided under this Plan for home health care.
Rehabilitation services provided under an authorized home health care plan will be covered as home health care Services.

Home health care benefits do NOT include:

1. Charges for mileage or travel time to and from your home;
2. Wage or shift differentials for Home Health Providers;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services include the following:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment (DME), medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in

planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.5.

All Direct to Consumer genetic tests are considered investigational and are not covered.

4.12.2 Inborn Errors of Metabolism

The Plan will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.

4.12.5 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

- All stages of reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and

- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in section 4.12.7.

<u>Outpatient Hospitalization and Anesthesia for Limited Dental Services</u>

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services using your In-Network benefits as shown in the Benefit Summary. Covered Services include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic X-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 4.9.2 (Medical Appliances). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and
6. Surgical Services.

TMJ Services are covered as shown in your Benefit Summary; limits may apply.

Out-of-Network benefits do not apply to TMJ Services.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a Participating retail or specialty Pharmacy.

Self-administered chemotherapy is covered under your Outpatient Chemotherapy benefit. Self-administered chemotherapy is covered under your Prescription Drug benefit when that coverage results in a lower out-of-pocket expense to the Member (See section 4.14).

4.12.9 Chiropractic Manipulation

Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.10 Acupuncture

Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.11 Massage Therapy

Coverage is provided for massage therapy as stated in the Benefit Summary. To be eligible for coverage, all massage therapy Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.12 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.13 Elective Sterilization

Coverage is provided, as stated below, for voluntary sterilization (tubal ligation and vasectomy).

All Covered Services must be received from Qualified Providers and Facilities.

- In-Network: Services are covered in full.
- Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g., your Inpatient or Outpatient Surgery benefit.

***Please note*:** Providence Health Plan is a Catholic-sponsored health plan, and, as a matter of conscience, Providence Health & Services facilities do not offer these Services. Services are available at other In-Network facilities.

4.12.14 Hearing Loss Services

Definitions:

Cochlear Implant

Cochlear Implant means a device that can be surgically implanted under the skin in the bony area behind the ear (the cochlea) to stimulate hearing.

Hearing Aid

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries or accessory for the instrument or device, except cords.

Covered Services:

The following hearing loss services are covered under this Plan as described below. Benefits for such services are provided at the applicable benefit level for that particular type of service, as listed in your Benefit Summary.

All Covered Services must be Medically Necessary and appropriate, and prescribed, fitted, and dispensed by a licensed audiologist, hearing aid/instrument specialist, or other Qualified Practitioner.

Cochlear implants:

Cochlear implants for one or both ears, including programming, reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.

Hearing aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year.

Diagnostic & Treatment Services:

Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit.

Hearing Assistance Technology:

- Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.

Limits to Hearing Loss Services

Coverage for hearing loss services are provided in accordance with state and federal law.

4.12.15 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.12.16 Biofeedback

Coverage is provided, as shown in the Benefit Summary for biofeedback to treat migraine headaches or urinary incontinence. Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person's body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with Providence Health Plan (the Out-of-Network benefit does NOT apply to transplant Services);
3. Involve one or more of the following organs or tissues:
    - Heart
    - Lung
    - Liver
    - Kidney
    - Pancreas
    - Small bowel
    - Autologous hematopoietic stem cell/bone marrow
    - Allogeneic hematopoietic stem cell/bone marrow; and
4. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel expenses are not covered for donors.)

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other Health Benefit Plan or government funding program. Covered Services for donors include:

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for pre-transplant services and post-transplant services at the applicable Inpatient Hospital Services and Outpatient Facility Services benefit.

The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition, and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.

The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for those Services, as shown in the Benefit Summary, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member's Out-of-Pocket Maximum.

4.13.5 Transplant Prior Authorization

(See also section 3.5.)

To qualify for coverage under this Plan, all transplant-related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant;
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by Providence Health Plan;

- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions.

Prescription Drug Definition

The following are considered "Prescription Drugs":

1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription";
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Evidence Review Commission as effective for the treatment of a particular indication.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

You have access to Providence Health Plan's nationwide broad pharmacy network as published in our pharmacy directory.

Providence Health Plan Participating Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at www.ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.

- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.
- Participating Pharmacies may not charge you more than your Copayment or Coinsurance. Please contact Customer Service if you are asked to pay more or if you, or the pharmacy, have questions about your Prescription Drug Benefit or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at www.ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies.)
- Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.7.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances, and Deductibles.

4.14.2 Use of Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network Pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. Reimbursement is subject to your Plan's limitations and exclusions. You are responsible for any amounts above our contracted rates.

International prescription drug claims will only be covered when prescribed for emergent conditions and will be subject to your medical Emergency Services benefit and any applicable Plan limitations and exclusions.

4.14.3 Prescription Drug Formulary

The Formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives.

The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices that treat most medical conditions.

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See Section 6.1 under Claims Involving Prior Authorization and Formulary Exception.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the Formulary for your Plan, visit https://healthplans.providence.org/members/pharmacy-resources/.

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.

If you request a brand-name drug, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

Affordable Care Act Preventive Drugs

Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our Formulary and are covered at no cost when received from Participating Pharmacies as required by ACA. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. However, over-the-counter contraceptives do not require a written prescription pursuant to Oregon state law.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Participating Pharmacies; and
6. Opioids up to 7 days initial dispensing.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.

3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If Providence Health Plan removes a pharmacy from its network, we will notify you of this change at least 30 days in advance. Notification may be done via the online directory or letter depending on the circumstance.

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.
7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered

in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.

8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug Exclusions

In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows:

1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 16 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Over-the-counter (OTC) drugs or vitamins that may be purchased without a provider's written prescription, except as required by federal or Oregon state law;
9. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
10. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions or as required by federal or Oregon state law;
11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. Drug kits unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (*e.g.,* gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and

21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.

4.14.9 Prescription Drug Disclaimer

Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, the following are specifically excluded from coverage under this Plan.

General Exclusions:

The Plan does not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition);

The Plan does not cover:

- Charges that are in excess of the Usual, Customary and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as provided in section 4.3.2.
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.6 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 4.12.16;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.9 and 4.12.10;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;

- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;
- Recreation services, therapeutic foster care, wraparound services, emergency aid for household items and expenses; services to improve economic stability, and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;

- All services related to artificial insemination, including charges for semen harvesting and storage;
- All services and prescription drugs related to fertility preservation;
- Diagnostic testing and associated office visits to determine the cause of infertility;
- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
  - Physical examination;
  - Related laboratory testing;
  - Instruction;
  - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
  - Related supplies and prescriptions.

For the purpose of this exclusion:

- Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
- Artificial reproduction means the creation of new life other than by the natural means.

- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism; and
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.13.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth; dental implants), except as approved by us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

6. CLAIMS ADMINISTRATION

This section explains how the Plan treats various matters having to do with administering your benefits and/or claims, including situations that may arise in which your health care expenses are the responsibility of a source other than this Plan.

6.1 CLAIMS PAYMENT

The Plan's payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly and pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to the Plan of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber's estate, unless payment to other parties is authorized in writing by you.

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after your claim has been processed. An EOB is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If your claim is denied under the Plan, Providence Health Plan will send an EOB to you with an explanation of the denial within 30 days after your claim is received. If additional time is needed to process your claim for reasons beyond Providence Health Plan's control, you will be sent a notice of delay explaining those reasons within 30 days after your claim if received. The processing will then be completed and you will be sent an EOB within 45 days after your claim is received. If additional information is needed from you to complete the processing of your claim, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you is received, Providence Health Plan will complete the processing of the claim within 30 days.

Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)

- **For Prior Authorization services that do not involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete their review and provide written notice of its decision to the Member and the provider. If the information is not received within 15 days, the request will be denied.

- For Prior Authorization of services that involve urgent medical conditions: You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.
- For Formulary exceptions: For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.

Claims Involving Concurrent Care Decisions. If an ongoing course of treatment for you has been approved under the Plan and it is determined through Concurrent Review procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request a reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. You will then be notified of Providence Health Plan's reconsideration decision within 24 hours after your request is received.

6.1.1 Timely Submission of Claims

The Plan will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if Providence Health Plan receives documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon insurance Division's administrative rule setting standards for prompt payment. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

6.1.2 Right of Recovery

The Plan has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from the Plan under any contract.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and

may reduce the benefits payable so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If the Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If the Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If the Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because the Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

6.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
        a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
            i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or
            ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
        b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
            ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care

coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- The Plan covering the Dependent spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:

i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.

ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not

agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than would have paid had This Plan been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, benefits may be reduced so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give us any facts Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

6.2.6 Right of Recovery

If the amount of the payments made by This Plan is more than what should have paid under this COB section, This Plan may recover the excess from one or more of the persons This Plan paid or for whom This Plan have paid; or any other person or organization that may be

responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions.

In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B.

When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare.

Counting individuals for the Employer size:

- Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.
- Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member's policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for the Plan to deny any claims for benefits arising from the condition or to terminate the Member's coverage under this Plan as specified in section 9.4. In addition, you or the Member must execute and deliver to the Plan and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and the Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the Plan or the Member. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member's heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any

person or for which the Member or the Member's heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, the Plan will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Plan.

If the Plan makes claim payments on any Member's behalf for any condition for which a third party is responsible, the Plan is entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery.

"Subrogation" means that the Plan may collect directly from the third party to the extent the Plan has paid for third-party liabilities. Because the Plan has paid for the Member's injuries, the Plan, rather than the Member, is entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify the Plan in writing of any terms or conditions offered in settlement and must notify the third party of the Plan's interest in the settlement established by this provision.

To the maximum extent permitted by law, the Plan is subrogated to the Member's rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member's name, and has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

To accomplish this process, the Plan needs detailed information from you or from the Member. A questionnaire will be sent to the Member for this information. It should be completed and returned to Providence Health Plan as soon as possible to minimize any claim review delay. If you or the Member has any questions or concerns regarding the questionnaire, please contact Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason the Plan is not paid directly by the third party, the Plan is entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and the Plan may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by the Plan, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, the Plan is entitled to the proceeds whether or not the loss is deemed to be compensable under the workers'

compensation laws. The Plan is entitled to recover up to the full value of the benefits provided by the Plan for the condition, calculated using the Plan's UCR charges for such Services, less the Plan's pro-rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. The Plan is entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Plan, the Member acknowledges the Plan's first priority to this repayment and assigns to us any benefits the Member may have from other sources. The Member must cooperate fully with the Plan and Providence Health Plan in recovering amounts paid by the Plan. If any Member seeks damages against the third party for the condition and retains an attorney or other agent for representation in the matter, that Member agrees to require the Member's attorney or agent to reimburse the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan directly from any settlement or recovery. The Plan may withhold benefits for the Member's condition until a signed copy of this agreement is delivered to the Plan. The agreement must remain in effect and the Plan may withhold payment of benefits if, at any time, the Member's confirmation of the obligations under this section should be revoked. While this document is not necessary for the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that the Plan would otherwise be required to pay under this Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, the Plan is not required to provide coverage for continuing treatment until the Member proves to the Plan's satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. The Plan will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using the Plan's UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. The Plan is entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate you for your medical expenses, regardless of any allocation of proceeds in any settlement document that the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled Family Member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 6.3.2 and 6.3.3 above are modified as provided below.

Before the Plan will be entitled to recover from under a settlement or recovery, you or your enrolled Family Member must first have received full compensation for your injuries. The Plan's entitlement to recover will be payable only from the total amount of the recovery in excess of the amount that fully compensates for the injured person's injuries.

The Plan will not deny or refuse to provide benefits otherwise available to you or your enrolled Family Member because of the possibility that a third party recovery may potentially be available against the person who caused the accident or out of motor vehicle liability or underinsurance coverage.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Your Customer Service representative is available to provide information and assistance. You may call or meet with Providence Health Plan at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:

- Availability, delivery or quality of a health care service;
- Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an internal review. You may request review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or grievance with Providence Health Plan. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or Appeal and Providence Health Plan will consider that information in the review process.
- You can be represented by anyone of your choice at all levels of Appeal.

Request for Claim/Appeal File and Additional Information:

- You can, upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to our decision at any time before, during, or after the appeal process. This includes the specific internal rule, guidelines, protocol, or other similar criterion relied upon to make the Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable.
- You also have the right to request free of charge, at any time, the diagnostic and treatment codes and their meanings that are the subject of your claim or appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.

If you received the services that were denied in the Adverse Benefit Determination, and if the Adverse Benefit Determination is upheld by internal or external review, you will be financially responsible for any benefits paid by the Plan for such services.

To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. We will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines as noted below.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling a Customer Service representative at 503-574-7500 or 800-878-4445 outside the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. Providence Health Plan will let

you know by phone and letter if your case qualifies for an expedited review. If it does, you will be notified of the decision within 72 hours of receiving your request.

Grievances and Appeals Involving Concurrent Care Decisions: If Providence Health Plan has approved an ongoing course of treatment for you and determines through medical management procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary, you may request an external review by an IRO. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary.**

The Plan pays for all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal or requests for External Review to 503-574-8757 or 800-396-4778, or you may hand deliver it *(if mailing, use only the post office box address listed above)* to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

If you decline coverage or fail to enroll when you first become eligible, the next earliest time you may enroll is the next occurring Open Enrollment Period.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

Clackamas County will provide an Open Enrollment Period each Plan Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Plan Year for which they enroll.

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

In instances where an Eligible Family Dependent of a Subscriber qualifies for a "special enrollment period," the Subscriber and the Eligible Family Dependent may:

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) because of other health coverage and you lose that other coverage, the Plan will provide a "special enrollment period" for you and/or your Eligible Family Dependent if:

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and
b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and
c) Such coverage:
    - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
    - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
        1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or

2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or
3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

Effective Date: Coverage under this Plan will take effect on the first day after the other coverage ended.

8.3.2 New Dependents

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.

The "special enrollment period" shall be a period of 60 days and begins on the later of:

- the date Dependent coverage is made available under this Plan; or
- the date of the marriage, birth, or adoption or placement for adoption.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

If you or your Eligible Family Dependent were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent

becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children's Health Insurance Program (CHIP)-sponsored arrangement, the Plan will provide a "special enrollment period" for you and your Family Member(s) if you request enrollment within 60 days after the date of entitlement.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

For the Subscriber, a leave of absence granted under the federal Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

Termination of Member coverage under this Plan will occur on the earliest of the following dates:

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County of any changes in eligibility including the lack of eligibility of a Family Member. Coverage will not continue beyond the last date of eligibility, regardless of the lack of notice to Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered Dependents the benefits paid as a result of such wrongful activity. Providence Health Plan will provide all affected Plan participants with 30 days' notice before rescinding coverage.

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated because you have engaged in fraudulent, dishonest or threatening behavior, such as:

1. You have filed a false claim with the Plan;
2. You willfully fail to provide information or documentation required to be provided under this Plan or knowingly provide incorrect or incomplete information;
3. You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County reserves the right at any time to terminate or amend in whole or part any of the provisions of the Plan or any of the benefits provided under the Plan. Any such termination or amendment may take effect retroactively or otherwise. In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction and no payments scheduled to be made on or after such effective date will result in any liability to the Plan or Clackamas County.

10. CONTINUATION OF GROUP MEDICAL BENEFITS

If you become ineligible for coverage under this Plan you may, under certain circumstances, continue group coverage. There are specific requirements, time frames and conditions that must be followed in order to be eligible for continuation of group coverage and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that applies to most Employers with 20 or more employees. Some Employers, such as church groups and state agencies, may be exempt from COBRA. The law requires that Employers subject to COBRA offer Employees and/or their Dependents continuation of medical and dental coverage in certain instances where there is a loss of group coverage.

10.1.1 Subscriber's Continuation Coverage

A Subscriber who is covered under this Plan may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

A Spouse or Domestic Partner who is covered under this Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the Subscriber and the Spouse;
- Termination of the domestic partnership; or
- The Subscriber becomes covered under Medicare.

10.1.3 Dependent's Continuation Coverage

A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours;
- The Subscriber's divorce or legal separation;
- Termination of the domestic partnership;
- The Subscriber becomes covered under Medicare; or
- The child ceases to qualify as an Eligible Family Member under this Plan.

A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 Notice Requirements

A Family Member's coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs or a child loses Dependent status under this Plan. **Under COBRA, you or your Family Member has the responsibility to notify Clackamas County if one of these events occurs.** Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When Clackamas County receives notification of one of the above "qualifying" events, you will be notified that you or your Family Member, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, your right to elect continuation coverage under this Plan will be lost.

10.1.5 Type of COBRA Continuation Coverage

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

10.1.6 COBRA Election Rights

A Subscriber or their Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

10.1.7 COBRA Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay the premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.

10.1.8 Length of COBRA Continuation Coverage

18-Month Continuation Period

When coverage ends due to a Subscriber's termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the Subscriber and all covered Family Members will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

29-Month Continuation Period

If a qualified beneficiary is disabled, continuation coverage for that qualified beneficiary and their covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides Clackamas County with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days.

36-Month Continuation Period

If a Spouse, Domestic Partner or Dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The Subscriber's death;
- The Subscriber's eligibility for Medicare;
- Divorce or legal separation;
- Termination of the domestic partnership; or
- A child becomes ineligible for Dependent coverage.

10.1.9 Extension of Continuation Period

If a second qualifying event occurs during the initial 18- or 29-month continuation period (for example, the death of the employee, divorce, or child loses status as an Eligible Family Member under the Plan), coverage for a qualified beneficiary may be extended up to 36 months. However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a Spouse or Dependent child has continuation coverage due to the employee's termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee's Medicare entitlement date.

10.1.10 Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the Pension Benefit Guaranty Corporation (PBGC), to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of sixty-five percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY caller may call toll-free at 866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

10.1.11 When COBRA Continuation Coverage Ends

COBRA Continuation coverage will end automatically for you and your Family Members when any of the following events occurs:

- Clackamas County no longer provides health coverage to any employees;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary (employee, spouse or dependent child) later becomes covered under another health plan;
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. Providence Health Plan wants you to have a positive experience, and are ready to help in any way.

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and In-Network Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS)

The following information applies to Members (participants) who are covered by a plan that is not subject to ERISA.

As a participant in Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, provided you request it in writing and reasonably describe the information.
    - You may obtain copies, subject to paying a reasonable copying charge.
    - You are entitled to know to whom we may have disclosed any such information.
    - You are entitled to correct any errors in the information.

2. Continue group health coverage
    - Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.1.
3. Enforce your rights

    If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

    As more fully described in section 7, the Plan offers a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (IRO) decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2.

    Member's sole right of Appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between the Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A child of an Eligible Employee will be enrolled in the Plan as required by a qualified medical child support order. The procedures and rules regarding this enrollment are described in this section.

12.1 DEFINITIONS

For purposes of this section, the following definitions shall apply:

"Alternate Recipient" means any child of an employee who is recognized under an Order as having a right to enrollment under the Plan with respect to such employee.

An "Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (or through an administrative process established under a state law which has the effect of a court order) which:

- Provides for child support with respect to a child of an employee under the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or
- Enforces a state law relating to medical child support with respect to the Plan.

A "Qualified Medical Child Support Order" or "QMCSO" means an Order:

- Which creates or recognizes the existence of an Alternate Recipient's right to receive, or assigns to an Alternate Recipient the right to receive, benefits for which an employee or beneficiary is eligible under the Plan; and
- With respect to which Clackamas County has determined satisfies the QMSCO standards set forth below.

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section.

"Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County will promptly notify the employee and each Alternate Recipient identified in such Order of the receipt of such Order, and will further furnish them each with a copy of these Procedures. If the Order or any accompanying correspondence identifies a Designated Representative, then copies of the acknowledgment of receipt notice and these Procedures will also then be provided to such Designated Representative.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County will determine whether the Order satisfies the QMCSO standards described below so as to constitute a QMCSO, and shall thereupon notify the employee, each Alternate Recipient, and any Designated Representative of such determination.

An Order will not be deemed to be a QMCSO unless the Order:

(a) Clearly specifies:
    1. The name and last known mailing address (if any) of the employee and of each Alternate Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);
    2. Either a reasonable description of the type of coverage to be provided under the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
    3. The period to which the Order applies.

(b) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

If an Order contains inconsistencies or ambiguities that might pose a risk of future controversy or liability to the Plan, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to Clackamas County will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been voluntary enrolled in the Plan by the employee as a dependent of such employee, including in regard to the payment by the employee for dependent coverage under the Plan. The amount of any required contributions to be made by the Employee for coverage under the Plan will be determined on the basis of the Alternate Recipient being treated as the employee's covered dependent. Any additional required contribution attributable to the coverage of the Alternate Recipient will not be separately charged. Rather, the full amount of the required contribution shall be paid by the employee in accordance with the payroll deduction or other procedures of the Plan as pertaining to the employee.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the employee. Rather, such reimbursement will be paid either to the Alternate Recipient, or to the custodial parent or legal guardian of such Alternate Recipient. However, if the name and address of a State or agency official has been substituted in the Order for that of the Alternate Recipient, then the reimbursement will be paid to such named official.

12.7 STATUS OF ALTERNATE RECIPIENT

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the Employee under the Plan to which the Order pertains.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County receives an appropriately completed National Medical Support Notice (a "National Notice") issued pursuant to the Child Support Performance and Incentive Act of 1998 in regard to an employee who is a non-custodial parent of a child, and if the National Notice is determined by Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, shall within forty (40) business days after the date of the National Notice notify the State agency issuing the National Notice of the following:

(a) Whether coverage of the child at issue is available under the terms of the Plan, and if so, as to whether such child is covered under the Plan; and
(b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the State or agency official acting on behalf of the child) to effectuate the coverage under the Plan.

Clackamas County shall within such time period also provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the Plan, upon receipt of a National Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as in effect immediately before receipt of such National Notice.

13. GENERAL PROVISIONS

13.1 CONFLICTS OF PROVISIONS

In the event that one or more provisions of this document conflict with one or more provisions of any other plan document, the provisions of this document, as from time to time amended, shall control.

13.2 CONTROLLING STATE LAW

To the extent not preempted by federal laws, the laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the Plan.

13.3 DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, the Plan will pay only under the provision allowing the greater benefit. This may require a recalculation based upon both the amounts already paid and the amounts due to be paid. The Plan has NO liability for benefits other than those this Plan provides.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 GENDER AND NUMBER

Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

13.6 HEADINGS

All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth there under.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2. If ERISA does not apply (see section 11.2) the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND PROVISIONS

The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other employee benefits plan maintained by Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Plan. Neither Clackamas County nor Providence Health Plan will have any liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Providence Health Plan. They will assist you in understanding and complying with the terms of the Plan.

13.10 MEMBERSHIP ID CARD

The membership ID card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

13.11 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is nontransferable.

13.12 NO GUARANTEE OF EMPLOYMENT

Neither the maintenance of the Plan nor any part thereof shall be construed as giving any employee covered hereunder any right to remain in the employ of Clackamas County. No shareholder, director, officer, or employee of Clackamas County in any way guarantees to any Member or beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

13.13 NO RECOURSE FOR ACTS OF PROVIDERS

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. Neither Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 NON-WAIVER

No delay or failure when exercising or enforcing any right under this Plan shall constitute a waiver or relinquishment of that right, and no waiver or any default under this Plan shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Plan shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Providence Health Plan, P.O. Box 3125, Portland, OR 97208.

13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly by an Out-of-Network Provider and you pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to Providence Health Plan of the payment. Payment will be made to the Member, subject to written notice of claim, or, if deceased, to the Member's estate, unless payment to other parties is authorized in writing by you. (See section 6.1.1 regarding timely submission of claims.)

13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. Providence Health Plan, in their discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner considered advisable, to be expended for the person's benefit. PHP's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by Clackamas County and Providence Health Plan.

13.18 PHYSICAL EXAMINATION AND AUTOPSY

When reasonably required for purposes of claim determination, the Plan Sponsor shall have the right to make arrangements for the following examinations, at Plan expense, and to suspend the related claim determination until Providence Health Plan has received and evaluated the results of the examination:

- A physical examination of a Member; or
- An autopsy of a deceased Member, if not forbidden by law.

13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Members, by acceptance of the benefits of this Plan, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or their designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with Providence Health Plan any information relating to any condition for which benefits are claimed under this Plan. Providence Health Plan may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf. If you do not consent to the release of records or to discussions with providers, Providence Health Plan will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

13.20 REQUIRED INFORMATION TO BE FURNISHED

Each Member must furnish to Providence Health Plan such information as they consider necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Member of such true, full and complete information as may be requested.

13.21 RIGHT OF RECOVERY

Providence Health Plan, on behalf of the Plan, has the right, upon demand, to recover payments in excess of the maximum benefits specified in this Plan or payments obtained through fraud, error, or duplicate coverage. If reimbursement is not made to the Plan, Providence Health Plan is authorized by Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 SEVERABILITY

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

13.23 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

- Payment for benefits with respect to a Member under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Member, as required by a State Medicaid Plan;
- The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's enrollment as a Member or beneficiary in the Plan, or in determining or making any payments for benefits of the individual as a Member in the Plan; and
- Payment for benefits under the Plan shall be made to a state in accordance with any state law which provides that the state has acquired the rights with respect to a Member for items or services constituting medical assistance under a State Medicaid Plan.

For purposes of the above, a "State Medicaid Plan" means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

13.24 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees entering into or returning from service in the armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In general, USERRA provides that:

(a) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County to perform services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents) on a self-pay basis. The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 10. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:
    1. The end of the 24-month period beginning on the date on which the employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan sponsored by the Employer with administrative services provided by Providence Health Plan. The funding for the benefits is derived from the funds of the Employer. The Plan is not insured.

This Summary Plan Description constitutes the written instrument under which the Plan is maintained and this document replaces all previous Summary Plan Descriptions. The rights of any person whose employment has terminated, and the rights of such person's covered dependents, will be determined pursuant to the terms of the Plan as in effect on the date such employment terminated, except as may otherwise be specifically provided under the Plan.

14.2 PLAN INFORMATION

Plan Name: Clackamas County General County Employees Open Option Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The effective date of the Plan is January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
800-878-4445

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer shall be responsible for all fiduciary functions under the Plan except insofar as any such authority or responsibility is assigned by or pursuant to the Plan to another named fiduciary, or is delegated to another fiduciary by the Employer. The Employer has the discretionary authority to determine eligibility for benefits under the Plan and to interpret the terms of the Plan, unless it has delegated that authority as permitted by the Plan. In the event of such delegation, Providence Health Plan's determinations on the meaning of Plan terms may not be overturned unless found by a court to have been arbitrary and capricious. The allocation of administrative duties and the delegation of discretionary authority for the Plan are specified in the Administrative Services Agreement that has been executed by the Employer and Providence Health Plan.

14.7.1 COMPLETE ALLOCATION OF FIDUCIARY RESPONSIBILITIES

This section is intended to allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each. The performance of such responsibilities will be deemed a several and not a joint assignment. None of such responsibilities nor any other responsibility is intended to be shared by two or more of them unless such sharing will be provided by a specific provision of the Plan. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two will not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction will be deemed to be its sole responsibility, and the responsibility of the one receiving such direction will be to follow it insofar as such direction is on its face proper under the Plan and applicable law.

14.8 ENGAGEMENT OF ADVISORS

The Employer may employ on behalf of the Plan one or more persons to render advice with regard to any responsibility it may have under the Plan. Toward that end, the Employer may appoint, employ and consult with legal counsel, actuaries, accountants, investment consultants, physicians or other advisors (who may be counsel, actuaries, accountants, consultants, physicians or other advisors for the Employer) and may also from time to time utilize the services of employees and agents of the Employer in the discharge of their respective responsibilities.

14.9 INDEMNIFICATION

The Employer will indemnify its employees for any liability or expenses, including attorneys' fees, incurred in the defense of any threatened or pending action, suit or proceeding by reason of their status as a fiduciary with respect to the Plan, to the full extent permitted by law.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

The Employer reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the Plan, or any document forming part of the Plan.

14.10.2 Manner of Action

Any amendment or termination of the Plan or any part of the Plan shall be made by an instrument in writing reflecting that such change has been authorized by the Employer. Any such amendment or termination shall be effective as of the date specified in said instrument, or, if no date is so specified, as of the date of execution or adoption of said instrument. An amendment may be effected by establishment, modification, or termination of the Plan by appropriate action of the Employer. Any such amendment or termination may take effect retroactively or otherwise. An instrument regarding the establishment, modification or termination of the Plan which is executed by the Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 Effect on Benefits

Claims incurred before the effective date of a Plan change or termination will not be affected. Claims incurred after Plan changes will be covered according to the provisions in effect at the time the claim is incurred. Claims incurred after the Plan is terminated will not be covered. You will not be vested in any Plan benefits or have any further rights, subject to applicable law.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan may disclose de-identified summary health information to the Employer for purposes of modifying, amending or terminating this Plan. In addition, Providence Health Plan may disclose protected health information (PHI) to the Employer in accordance with the following provisions of this Plan as established by the Employer:

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) The Employer shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary

of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.

(i) The Employer shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) The Employer shall provide for adequate separation between the Employer and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of the Employer:

(k) Directors of Human Resources;

1. Benefit Managers;
2. Benefit Analysts;
3. Benefit Specialists; and
4. Internal Auditors, when performing Health Plan Audits.

Further, the Employer shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for the Employer with regard to this Plan. In addition, the Employer shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

14.11.2 Security

In accordance with the security standards of the Health Insurance Portability and Accountability Act (HIPAA), the Employer shall:

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;

(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and

(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

The following are definitions of important capitalized terms used in this Summary Plan Description.

Adverse Benefit Determination
See section 7.

Alternative Care Provider
Alternative Care Provider means a naturopath, chiropractor, acupuncturist, or massage therapist who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the documents with that title that are part of your Plan and summarize the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Chemical Dependency
Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Substance Abuse does not mean an addiction to, or dependency on, tobacco, tobacco products or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County General County Employees Open Option Plan
Clackamas County General County Employees Open Option Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant
See section 4.12.14.

Coinsurance
Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

Confinement
Confinement means being a resident patient in a Hospital, Skilled Nursing Facility or Qualified Treatment Facility for at least 15 consecutive hours. Successive Confinements are considered to be one Confinement if:

1. Due to the same injury or illness; and
2. Separated by fewer than 30 consecutive days when you are not confined.

Contribution
Contribution means the monetary amount that an Employee is required to contribute as a condition to coverage under the Plan. Specific Contribution amounts are available from your Human Resources office.

Copayment
Copayment means the dollar amount that you are responsible for paying to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary.

Cosmetic Services
Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

1. Listed as a benefit in the Benefit Summary and in section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; and
4. Provided to you while you are a Member and eligible for the Service under this Plan.

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care

Custodial Care means Services that:

1. Do not require the technical skills of a licensed nurse at all times;
2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
3. Are not likely to improve your medical condition.

Such Services will still be considered Custodial Care even if:

1. You are under the care of a physician;
2. The Services are prescribed by a Qualified Practitioner;
3. The Services function to support or maintain your condition; or
4. The Services are being provided by a registered nurse or licensed practical nurse.

Deductible

See section 3.11.1.

Dependent

Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.

Domestic Partner

A Domestic Partner means either of the following:

1. An Oregon Registered Domestic Partner is a person who:
    - Is at least 18 years of age;
    - Has entered into a Domestic Partnership with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
2. A domestic partner who is not an Oregon Registered Domestic Partner is a person at least 18 years of age who:
    - Shares a close personal relationship with a subscriber such that each is responsible for each other's welfare;
    - Is the subscriber's sole domestic partner;

- Is not married to any person and has not had another domestic partner within the prior six months;
- Is not related by blood to the subscriber as a first cousin or nearer;
- Shares with the subscriber the same regular and permanent residence, with the current intention of doing so indefinitely;
- Is jointly financially responsible with the subscriber for basic living expenses such as food and shelter;
- Was mentally competent to consent to contract when the domestic partnership began; and
- Has provided the required employer documentation establishing that a domestic partnership exists.

Note: All provisions of the Plan that apply to a spouse shall apply to a Domestic Partner.

Durable Medical Equipment (DME)
Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

E-mail Visit
E-mail visit (electronic provider communications) means a consultation through e-mail with an In-Network Provider that is, in the judgment of the In-Network Provider, Medically Necessary and appropriate and involves a significant amount of the In-Network Provider's time. An E-mail visit must relate to the treatment of a covered illness or injury (see also section 4.1.3).

Effective Date of Coverage
Effective Date of Coverage means the date upon which coverage under this Plan commences for a Member.

Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee
Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Open Option General County Employees, COBRA participants, Non-Medicare Eligible Early Retirees, and Job Share.
3. Work Hours: Regularly scheduled for at least 20 hours per week (18.75 hours for Job Share). Not applicable to COBRA participants and Non-Medicare Eligible Early Retirees.

4. Eligibility Waiting Period: Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

The limiting age for each Dependent child is 26 and such children shall become ineligible for coverage on the last day of the month in which their 26th birthday occurs.

A covered Dependent child who attains the limiting age remains eligible if the child is:

1. Developmentally or physically disabled;
2. Incapable of self-sustaining employment prior to the limiting age; and
3. Unmarried.

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under this Plan, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age. Thereafter, Providence Health Plan may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

Endorsement
Endorsement means a document that amends and is part of this Plan.

Essential Health Benefits
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

Exclusion
Exclusion means an item or service that is not a Covered Service under the Plan.

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In

determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are :

- Approved by the appropriate governmental regulatory body;
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient provider in the United States;
- Reviewed and supported by national professional medical societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. Providence Health Plan will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon request.

Family Member
Family Member means a Dependent who is properly enrolled in and entitled to Covered Services under this Plan.

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Grievance
See section 7.

Global Fee
See section 4.13.2

Health Benefit Plan
Health Benefit Plan means any Hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple Employer welfare arrangement or other benefit arrangement defined in the federal Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.14.

Hearing Assistance Technology
See section 4.12.14.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Provider
Home Health Provider means a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed

by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

Hospital

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home, Skilled Nursing Facility, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Substance Abuse or Mental Health disorders.

In-Network

In-Network means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services that are provided by an In-Network Provider.

In-Network Provider

In-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

Ineligible Person

Ineligible Person means any person who does not qualify as a Member under this Plan.

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

Medically Necessary

Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by Providence Health Plan.

The criteria are based on the following principles:

1. Covered Services are determined to be Medically Necessary if they are health care services or products that a Qualified Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing, preventing, or treating illness (including mental illness), injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice;
    i. Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Qualified Practitioner specialty society recommendations, the views of Qualified Practitioners practicing in relevant clinical areas, and any other relevant factors;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the Member's medical condition;
c. Not primarily for the convenience of the Member or Qualified Practitioner; and
d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's illness, injury or disease.

Prudent Clinical Judgment: The "prudent clinical judgment" standard of Medical Necessity ensures that Qualified Practitioners are able to use their expertise and exercise discretion, consistent with good medical care, in determining the Medical Necessity for health care services to be provided to each Member. Covered Services may include, but are not limited to, medical, surgical, diagnostic tests, substance abuse treatment, other health care technologies, supplies, treatments, procedures, drug therapies or devices.

Member
Member means a Subscriber or Eligible Family Dependent, who is properly enrolled in and entitled to Services under this Plan.

Mental Health
Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), such as but not limited to major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and substance use disorder.

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, during which Eligible Employees are given the opportunity to enroll themselves and their Dependents under the Plan for the upcoming Plan Year, subject to the terms and provisions as found in this Summary Plan Description.

Out-of-Network
Out-of-Network means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services provided by Out-of-Network Providers.

Out-of-Network Provider
Out-of-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital, Skilled Nursing Facility, or

Pharmacy that does not have a written agreement with Providence Health Plan to participate as a health care provider for this Plan.

Out-of-Pocket Maximum
See section 3.11.2.

Outpatient Surgical Facility
Outpatient surgical facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Pharmacy
Participating Pharmacy means pharmacy that has signed a contractual agreement with Providence health Plan to provide medications and other Services at special rates. There are four types of Participating Pharmacies:

1. Retail: A Participating Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
3. Specialty: A Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
4. Mail Order: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Plan
Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary and any Endorsements, amendments and addendums that accompany this document.

Plan Administrator
Plan Administrator means the "Administrator" or "Plan Administrator" as those terms are defined under ERISA and shall refer to the current or succeeding person, committee, partnership, or other entity designated as such by the terms of the instrument under which the Plan is operated, or by law. Regardless of the terms of the instrument under which the Plan is operated, Providence Health Plan is not the Plan Administrator.

Plan Year
Plan Year means a 12-month time period beginning January 1st and ending December 31st.

Primary Care Provider
Primary Care Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician who agrees to be responsible for the Member's continuing medical care by serving as case manager. Members may also choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a

certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

(Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the Provider Directory online or call Customer Service.)

Prior Authorization

Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.5. Prior Authorized determinations are not a guarantee of benefit payment unless:

- A determination that relates to benefit coverage and medical necessity is obtained no more than 30 days prior to the date of the Service; or
- A determination that relates to eligibility is obtained no more than five business days prior to the date of the Service.

Providence Health Plan

Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon and Washington that serves as the claims administrator with respect to this Plan.

Qualified Practitioner

Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, naturopath, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility

Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery

Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic

Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket, or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified as a "Skilled Nursing Facility" by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Spouse
Spouse means an individual who is legally married to the Subscriber in accordance with the laws of the country or state of celebration.

Subscriber
Subscriber means an employee or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

Summary Plan Description (SPD)
Summary Plan Description (SPD) means the description of the Plan as contained in this document, and includes the provisions of any Benefit Summary, any Endorsements, amendments and addendums that accompany these documents, and those policies maintained by Providence Health Plan which clarify any of those documents.

Termination Date of Coverage
Termination Date of Coverage means the date upon which coverage under this Plan ends for a Member. No coverage under the Plan will be provided beyond the Termination Date of Coverage.

Urgent Care
Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.

Urgent Care Covered Services are provided when your medical condition meets the guidelines for Urgent Care that have been established by Providence Health Plan. Covered Services do **NOT** include Services for the inappropriate use of an Urgent Care facility, such as: services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with In-Network Providers for that Service. UCR charges will never be less than Providence Health Plan's negotiated fees.

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Virtual Visit

Virtual Visit means a visit with a Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network or Out-of-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife, or licensed direct entry midwife practicing within the applicable lawful scope of practice.

16. NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

لحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا. اتصل بالرقم 1-800-878-4445 (رقم الهاتف 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 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's self-funded Employee Health Benefit Plan, Clackamas County General County Employees Open Option Plan. This document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for Clackamas County's Eligible Employees and Eligible Family Dependents. Those benefits are described in this Summary Plan Description.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed, effective as of January 1, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); or one of our Sales representatives at 503-574-6300 or 877-245-4077, 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

Clackamas Co GCE Open Option SPD
Effective January 01, 2021
Administered by Providence Health Plan

2021 Summary Plan Description

General County Employees Personal Option

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County has contracted with Providence Health Plan to process claims and provide customer service to Plan Members. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Mail order prescription drug services	ProvidenceHealthPlan.com
Medical, Mental Health, and Chemical Dependency Prior Authorization requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us" or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
- Our Providence Signature Network of In-Network Providers; and
- Providence Health Plan's national network of In-Network Providers.
- Covered Services must be obtained from In-Network Providers, with the following exceptions:
    - Emergency Services and Urgent Care Services, as specified in section 4.5;
    - Covered Services received by an enrolled Out-of-Area Dependent, as specified in section 3.5.2; and
    - Covered Services delivered by an Out-of-Network Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.7.
- All Members are encouraged to choose a Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of In-Network Providers in our Service Area is available at ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 3.7.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in Plan documents. You should read the provisions, limitation and exclusions before seeking Covered Services because not all health care services are covered by this Plan.
- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. Providence Health Plan is an Oregon licensed Health Care Services Contractor whose parent company is Providence Health & Services. Our goal is to help improve the health status of individuals in the communities in which we serve. This booklet contains important information about the health plan coverage offered to Clackamas County General County Employees and their Dependents.

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

Your Plan allows you to receive Covered Services from In-Network Providers.

It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is participating with Providence Health Plan, and whether or not the health care is a Covered Service even if you have been directed or referred for care by an In-Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit our Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, before you make an appointment. You can also call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

Whenever you visit a Provider:

- Bring your Providence Health Plan Member ID Card with you.
- Be prepared to make a Copayment at the time of visit if the office visit is subject to a Copayment.
- If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be able to pay for what you owe at the time of your visit. Your provider's office will send you a bill for what you owe later. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and bill or credit you for the balance later.

2.2 SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains important information about the health plan coverage offered to employees of Clackamas County. It is important to read this Summary Plan Description carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 15. If you need additional help understanding anything in this Summary Plan Description, please call Customer Service at 503-574-7500 or 800-878-4445. *See section 2.3 for additional information on how to reach Customer Service.*

This Summary Plan Description is not complete without your:

- **Clackamas County General County Personal Option Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, Copayments and Coinsurance for Covered Services and also provide other important information.

- **Provider Directory** which lists In-Network Providers, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need more detailed information for a specific problem or situation, contact your Employer or Customer Service.

2.3 CUSTOMER SERVICE

We want you to understand how to use your Providence Health Plan benefits and to be satisfied with your health plan coverage. Customer Service is available to assist you in understanding your benefits and resolving any problems you may have, including:
Specific benefit or claim questions.

Questions or concerns about your health care or service.

Contacting Providence Customer Service
Customer Service representatives are available by phone from 8 a.m. to 5 p.m., Monday through Friday, (excluding holidays). **Please have your Member ID Card available when you call:**

- **Members in the Portland-metro area, please call 503-574-7500.**
- **Members in all other areas, please call toll-free 800-878-4445.**
- **Members with hearing impairment, please call the TTY line 711**

You may **access claims and benefit information 24 hours a day, seven days a week** online through your myProvidence account.

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Summary Plan Description and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877-569-7768

2.5 YOUR MEMBER ID CARD

Each Member of Providence Health Plan receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member number and group number
- Important phone numbers

The Member ID Card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your Member ID Card, and pay your Copayment or Coinsurance.

Please keep your Member ID Card with you and use it when you:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse Customer Service.
- Call or correspond with Customer Service.
- Call Providence nurse advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.

2.6 PROVIDENCE NURSE ADVICE LINE

503-574-6520; toll-free 800-700-0481; TTY 711

The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6 for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching

Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for tobacco-use cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

Quit for Life can be reached at 866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account*, section 2.4 for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America
Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services for Providence Health Plan members. Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program. Please have your Providence Health Plan Member ID card ready, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information," we mean information that identifies you as an individual (such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain their medical records from their provider. Call your physician's or provider's office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represent a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan.

Providence Health Plan may disclose a Member's PHI to an employer or any agent of the Employer if the disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it.

3. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Primary Care Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing.

This section describes how to use this Plan and how benefits are applied. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is an In-Network Provider even if you have been directed or referred for care by an In-Network Provider.

3.1.1 Nationwide Network of In-Network Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services when using In-Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing an In-Network Provider

To choose an In-Network Provider, or to verify if a provider is an In-Network Provider, please refer to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request an In-Network Provider Information.

Your In-Network Provider will work with Providence Health Plan to arrange for any Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.7.

3.1.3 Indian Health Services Providers

Native American Indian and Alaskan Native Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from an In-Network Provider. For a list of IHS facilities, please visit the IHS website at www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend that upon joining Providence Health Plan you and each of your Family Members choose an In-Network Primary Care Provider as soon as possible.

3.2.1 Primary Care Providers

A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider.

Primary Care Providers provide preventive care and health screenings, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Primary Care Providers offer maternity care and minor outpatient surgery as well.

IMPORTANT NOTE: In-Network Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our In-Network Providers with the specialties listed above are In-Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated In-Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend that you choose a Primary Care Provider from our Provider Directory, available online, for each covered Family Member. Call the provider's office to make sure they are accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

- What are the office hours?
- How can I get medical advice after hours?
- What do I do in an emergency?

Let your Primary Care Provider know if you are under a specialist's care as well as if you are currently taking any ongoing prescription medications.

3.2.4 Changing Your Primary Care Provider

You are encouraged to establish an ongoing relationship with your Primary Care Provider. If you decide to change your Primary Care Provider, please remember to have your medical records transferred to your new Primary Care Provider.

3.2.5 Office Visits

Primary Care Providers

We recommend you see your Primary Care Provider for all routine care and call your Primary Care Provider first for urgent or specialty care. If you need medical care when your Primary Care Provider is not available, the physician/provider on call may treat you and/or recommend that you see another provider for treatment.

Specialists

Your Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a specialist for your treatment.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who is an In-Network Provider with Providence Health Plan.

If you decide to see a specialist on your own, we recommend you let your Primary Care Provider know about your decision. Your Primary Care Provider will then be able to coordinate your care and share important medical information with your specialist. In addition, we recommend you let your specialist know the name and contact information of your Primary Care Provider.

Whenever you visit a specialist:

- Bring your Providence Health Plan Member ID Card.
- Understand that in most cases, your out-of-pocket costs will be a percent of the charges for services. Your provider's office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and will bill or credit you the balance later. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Alternative Care Providers

This Plan includes coverage for office visits to alternative care providers, as listed in your Benefit Summary. See section 15 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.9, 4.12.10 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

Providence Health Plan may approve and provide reimbursement for Out-of-Network Qualified Practitioners and facilities. Benefits for Covered Services by an Out-of-Network provider will be provided as shown in the Benefit Summary when we determine **in advance**, in writing, that the Out-of-Network Provider possesses unique skills which are required to adequately care for you and are not available from In-Network Providers.

Under no circumstances (with the exception of Emergency and Urgent Care) will we cover Services received from an Out-of-Network Provider/Facility *unl*ess we have Prior Authorized the Out-of-Network Provider/Facility and the Services received.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If the approved, Prior Authorized Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Provider, those Services are still subject to the terms of this Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

It is important for you to understand that Providence Health Plan has not assessed the approved, Prior Authorized Out-of-Network Provider's credentials or quality; nor has Providence Health Plan reviewed and verified the Out-of-Network Provider's qualifications and history for information such as: relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Additionally, the Out-of-Network Provider will not have been assessed by Providence Health Plan to verify that the provider meets certain criteria relating to professional competence and conduct and as such is not guaranteed to follow your benefit plan, rules, regulations, or guidelines with regard to standards of care nor standards of documentation and billing.

Payment for Out-of-Network Physician/Provider Services (UCR)
After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Network benefits as shown in the following example (amounts shown are only estimates of what may apply).

	Provider's Status	
Item	In-Network	Out-of-Network
Provider's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount that the provider may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.

Payment for Covered Services Provided Before Disposition of Criminal Charges

If you are in the custody of an Oregon state or local corrections agency pending the disposition of criminal charges brought by an Oregon county, we will reimburse the custodial county for the costs of Covered Services or supplies rendered before the disposition of charges, in an amount that is no less than 115 percent of the Medicare rate for the service or supply, except for renal dialysis which will be reimbursed in accordance with the terms of the Plan for Out-of-Network dialysis providers.

The following Services and Supplies are excluded from coverage under this section:

- Diagnostic tests or health evaluations required by the corrections agency, as a matter of course, for all individuals who are in the custody of the county pending the disposition of charges;
- Hospital and ambulatory surgical center services, except as rendered by an In-Network provider.

3.4 MOVING INTO OR OUT OF THE SERVICE AREA

If you or a Family Member permanently moves into or out of the Service Area, you must immediately notify us and your Employer as such a move may affect your benefits or coverage under this Personal Option Plan. We will determine how this move affects your coverage and will inform you of any changes. If you have Dependent(s) who move in or out of our Service Area, a Change of Status form for those Dependent(s) must be completed and returned to us as soon as possible. This form can be obtained from us or from your Employer. See section 8.3.1 for more information.

3.5 OUT-OF-AREA DEPENDENTS

Dependents of a subscriber on a Personal Option Plan who live outside the Providence Health Plan Service Area (including dependents who are away at school) are eligible to become Out-of-Area Dependent Members. *See "Definitions" section 15, for the definition of "Eligible Family Dependent" and "Out-of-Area Dependent."* This section discusses how Enrolled Out-of-Area Dependent Personal Option Plan Members obtain covered services through Providence Health Plan's enrolled Out-of-Area Dependent benefit.

3.5.1 Out-of-Area Dependent Enrollment

To apply for Personal Option Out-of-Area Dependent benefits, complete an Out-of-Area Dependent Enrollment form, available from your Customer Service team. **If you do not complete an Out-of-Area Dependent Enrollment form, your Out-of-Area Dependent will not be covered for Out-of-Area Dependent benefits.**

3.5.2 Out-of-Area Dependent Coverage

When you enroll for Out-of-Area Dependent coverage, we will send you an Out-of-Area Dependent Benefit Summary. As stated in your Benefit Summary, a Dependent with Out-of-Area benefits may see any provider, in or out of the Service Area. Please refer to your Out-of-Area Dependent Benefit Summary for detailed Coinsurance or Copayment and annual Out-of-Pocket Maximum information. (For Out-of-Area Dependents who are covered by a government sponsored health plan of a county other than the United States, coverage under this Personal Option Out-of-Area Dependent plan will be secondary and will not replace or duplicate coverage available under the government sponsored plan.) Our payment is based on usual, customary and reasonable (UCR) charges. Charges which exceed UCR charges are your responsibility.

You must purchase your prescription drugs at one of our nationwide Participating Pharmacies (see section 4.14.1**.** A list of our Participating Pharmacies is available online at www.ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Participating Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Copayment and Coinsurance, if applicable, and on how to use this benefit.

3.5.3 Out-of-Area Dependents and Change of Status

Enrolled Out-of-Area Dependents may change to In-Area or Out-of-Area status by contacting us and completing a status change enrollment form. The change will be effective the date you specify or if no date is specified, on the first of the month following our receipt of the enrollment form. Retroactive changes are limited to 30 days.

3.5.4 Out-of-Area Dependents Prior Authorization

Enrolled Out-of-Area Dependents are responsible for obtaining Prior Authorization from Providence Health Plan prior to receiving certain services from Out-of-Network Providers. For further information about Prior Authorization, including a list of these Covered Services and how to obtain Prior Authorization, see section 3.7.

You must contact us to obtain Prior Authorization for specified Covered Services if the Services are to be received from an Out-of-Network Provider. See section 3.7.

3.6 NOTICE OF PROVIDER TERMINATION

When an In-Network Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within 10 days of the termination date or of our knowledge of the termination date.

3.7 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from In-Network Providers:
When Services are received from an In-Network Provider, the In-Network Provider is responsible for obtaining Prior Authorization.

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your Out-of-Network Provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.8.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.3.
- All Applied Behavior Analysis, as provided in section 4.10.2.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.
- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.

- Certain medications, including certain immunizations, received in your Provider's office, as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

Providence Health Plan will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call Customer Service at the number listed on your Member ID Card.

If an Emergency Medical Condition exists which prevents you from obtaining Prior Authorization, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

Prior Authorization Requests for Out-of-Network Services:

- The Member or the Out-of-Network Provider must call us at 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:
- The Member's name and date of birth.
- The Member's Providence Health Plan Member number and Group number (these are listed on your Member ID card).
- The Provider's name, address and telephone number.
- The name of the Hospital or treatment facility.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

Failure to Obtain Prior Authorization:
If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary.

3.8 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.9 MEDICAL COST MANAGEMENT

Coverage under this Plan is subject to the medical cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

The Plan reserves the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by Providence Health Plan. When more than one medically appropriate alternative is available, Providence Health Plan will approve the least costly alternative.

In accordance with Providence Health Plan's medical cost management protocols and criteria specified in this paragraph, Providence Health Plan may approve substitutions for Covered Services under this Plan.

A Substituted Services must:

1. Be Medically Necessary;
2. Have your knowledge and agreement while receiving the Service;
3. Be prescribed and approved by your Qualified Practitioner; and
4. Offer a medically therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

The Plan's coverage of a Substituted Service for any Member does not obligate the Plan to:

- Cover a Substituted Service for any other Member;
- Continue to cover a Substituted Service beyond the term of the agreement between the Plan and the Member; or
- Cover any Substituted Service for the Member, other than as specified in the agreement between the Plan and the member.

Substituted Services that satisfy the requirements of this section are Covered Services for all purposes under this Plan.

A Substituted Service may be disallowed at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.

3.9.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

Providence Health Plan has developed standards to guide the evaluation process and to ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage:

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

A committee of medical directors with physician specialist advisors evaluates all new technology and determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services that provide independent analysis of a new technology.

Expedited Review

Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 7.

3.10 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.

- ***Example:*** *Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.*
- ***Example:*** *You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor's office. The Plan would not pay for that visit.*
- ***Example:*** *You stay an extra day in the hospital only because the relative who will help you during recovery cannot pick you up until the next morning. We may not pay for the extra day.*

Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.11 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial offered through an In-Network provider.

Covered Services include the routine patient costs for items and services received from In-Network providers and facilities in connection with the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services under the Plan.

You may choose to participate in an Approved Clinical Trial offered through an Out-of-Network provider. However, coverage will only be provided for Medically Necessary services received In-Network in treatment of an illness or injury.

The following costs are excluded:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- The cost for any services received Out-of-Network.

The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for services unrelated to a clinical trial to the extent that the services are otherwise Covered Services under the Plan.

3.12 HOW BENEFITS ARE APPLIED

Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:

1. The Deductible;
2. The Copayment or Coinsurance amount; and
3. The benefit limits and/or maximums.

3.13 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Your Plan has a Deductible and an Out-of-Pocket Maximum, as stated in your Benefit Summary.

Deductible amounts apply to Out-of-Pocket Maximums.

3.13.1 Understanding Deductibles

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year when receiving most Covered Services before benefits are provided by us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

Certain Covered Services, such as most In-Network preventive care, are covered without a Deductible. Please see your Benefit Summary for information about these Services.

Individual Deductible: An Individual Deductible is the amount shown in the Benefit Summary that must be paid by a Member before the Plan provides benefits for Covered Services for that Member.

Family Deductible: The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Members are enrolled in this Plan, and is the maximum Deductible that enrolled Family Members must pay. All amounts paid by Family Members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled Family Members.

Note: No Member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services for that Member.

Your Costs that Do Not Apply to Deductibles: **The following out-of-pocket costs do not apply towards Your Individual and Family Deductibles:**

- Services not covered by this Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

3.13.2 Understanding Out-of-Pocket Maximums

Out-of-Pocket Maximums are the total amount you will pay out-of-pocket in any Calendar Year for Covered Services received under this Plan. See your Benefit Summary.

Individual Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

Family Out-of-Pocket Maximum: Family Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a family of two or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment, Coinsurance and Deductible expenses of enrolled Family Members meet the family Out-of-Pocket Maximum, all remaining individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Note: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

Your Costs that Do Not Apply to Out-of-Pocket Maximums: The following out-of-pocket costs do not apply toward your Individual and Family Out-of-Pocket Maximums:

- Services not covered by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.7;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

IMPORTANT NOTE: Some Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services, as shown in the Benefit Summary, remains in effect throughout the Calendar Year.

4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

You must use In-Network Providers to receive the Covered Services listed in this section, unless you are an Enrolled Out-of-Area Dependent or have received Prior Authorization to receive services from an Out-of-Network Provider.

Benefits are provided for preventive care and for the treatment of illness or injury when such treatment is Medically Necessary and provided by a Qualified Practitioner as described in this section and shown in the Benefit Summary.

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section4.2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, http://www.hrsa.gov/womens-guidelines.

Note: Additional Plan provisions apply to some Services (e.g., to be covered in full, routine physical examinations and well-baby care must be received from an In-Network Provider, see section 4.1.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly

enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

Infants up to 30 months:	Up to 12 well-baby visits.
Children and Adolescents:	
3 years through 21 years:	One exam every year.
Adults:	
22 years through 29 years:	One exam every five years.
30 years through 49 years:	One exam every two years.
50 years and older:	One exam every year.

If, at the time of your routine physical examination or well-child care, you need paperwork completed for a third party, such as school, camp, team sports, etc., your provider may charge you a fee to complete the paperwork. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.14.

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.

4.1.3 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by your Qualified Practitioner for men designated as high risk.

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations include:

- One fecal occult blood test per year, plus one sigmoidoscopy every five years; or
- One colonoscopy every 10 years; or

- One double contrast barium enema every five years.

Screening examinations and lab tests for Members designated as high risk are covered as recommended by your Qualified Practitioner.

All colonoscopy and sigmoidoscopy Services are covered in full, including prescription drug bowel prep kits as listed in our Formulary.

4.1.5 Preventive Services for Members with Diabetes

Preventive Covered Services for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- A dilated retinal exam by a qualified eye care specialist every Calendar Year;
- A glycosylated hemoglobin (HbA1c) test, a urine test to test kidney function, blood test for lipid levels as appropriate, a visual exam of mouth and teeth (dental visits are not covered), foot inspection, and influenza vaccine by a Qualified Practitioner every Calendar Year; and
- A pneumococcal vaccine every five years.

4.1.6 Diabetes Self-Management Education Program

Benefits are paid in-full for diabetes self-management education programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes as prescribed by a Qualified Practitioner. “Diabetes self-management program” means one program of assessment and training after diagnosis as well as assessment and training upon a material change of condition, medication or treatment. All services must be received from licensed providers and facilities, practicing within scope of license.

4.1.7 Nutritional Counseling

Nutritional counseling is covered when Medically Necessary, as shown in your Benefit Summary. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services

Coverage is provided for participation in a Providence Health Plan-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. “Tobacco use cessation program” includes educational and medical treatment components such as, but not limited to, counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of Providence Health Plan-approved programs is available online at www.ProvidenceHealthPlan.com (select “search” and enter “tobacco cessation” or by calling Customer Service at 503-574-7500 or 800-878-4445.

4.2 WOMEN’S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women’s Preventive Health Care Services from a Primary Care Provider or a Women’s Health Care Provider. Women’s Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners specializing in women’s health care, certified nurse midwives, and licensed direct entry midwives.

4.2.1 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and Pap examinations once every Calendar Year or more frequently for women who are designated high risk. Family planning Services are separate (see section 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider.

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Lactation Counseling Services must be received from licensed providers. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through In-Network Medical Equipment Providers.

4.2.4 Family Planning Services

Benefits include counseling, exams, and services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Network Pharmacy.

Services are covered in full and must be received from In-Network Providers and Facilities. Oral contraceptives must be purchased at Participating Pharmacies.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.13.

4.3 PROVIDER SERVICES

4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Some services provided by your Qualified Practitioner during your visit may result in additional Member financial responsibility.

For example – You see your Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific services, such as allergy shots, maternity care, and diagnostic services. See your Benefit Summary for details.

If you are unable to keep a scheduled office appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Providence Health Plan will not cover this expense.

4.3.2 Virtual Visits

The Plan provides coverage for Virtual Visits with In-Network Providers using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.
- Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers who may be approved for E-mail Visits. In-Network Providers who are authorized to provide E-mail Visits have agreed to use Internet security technology approved by us to protect your information from unauthorized access or release. To be eligible for the E-mail Visit benefit, you must have had at least one prior office visit with your In-Network Provider within the last 12 months.

Covered E-mail Visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by the Plan;
- Communications by the In-Network Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;

- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of e-mail communications that do not qualify as E-mail Visits include, but are not limited to:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
- All communications in connection with Mental Health or Substance Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service:

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site.

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

4.3.7 Immediate Care

Immediate Care is an extension of your Primary Care Provider's office, and provides additional access to treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Immediate Care Provider.

4.3.8 Retail Health Clinics

Coverage is provided as shown in the Benefit Summary for Covered Services obtained at Retail Health Clinics. Retail Health Clinics can provide diagnosis and treatment services for uncomplicated minor illnesses and injuries, like sore throats, ear aches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

4.4 DIAGNOSTIC SERVICES

Coverage is provided as shown in your Benefit Summary for Diagnostic Services.

4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

4.4.2 Sleep Study Services

Benefits are as shown in the Benefit Summary and include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

Benefits for Emergency Care and Urgent Care Services are provided as described below and shown in your Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

4.5.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Medically necessary detoxification
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Unexpected premature childbirth

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:
"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part;
- Place the health of a person, or any unborn child in the case of a pregnant woman, in serious jeopardy;
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child; or
- That is a behavioral health crisis.

"Emergency Services" means, with respect to an Emergency Medical Condition:

- An Emergency Medical Screening Exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"Emergency Medical Screening Exams" include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card.

Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care.

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

4.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary emergency care or to a facility specified by Providence Health Plan. Air ambulance transportation is only covered for a life-threatening medical emergency, or when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time. Ambulance transportation solely for personal comfort or convenience is not covered.

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions resulting from an injury to or illness of the eye(s). Members may receive Services directly from an optometrist or ophthalmologist or from a Hospital emergency room.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their office is not Urgent Care.

Whenever you need urgent care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable

Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Qualified Provider.

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

When you are admitted to an Out-of-Network Hospital from an Urgent Care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

Not all Out-of-Network facilities will file a claim on a Member's behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services.

- Covered Services do NOT include care received that consists primarily of:
- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases, the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

- Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital.

For Enrolled Out-of-Area Dependents: You are responsible for making sure inpatient hospitalization services are Prior Authorized by Providence Health Plan before receiving this care from an Out-of-Network Hospital.

Only Medically Necessary hospital services are covered. Covered inpatient Services received in a Hospital are:

- Acute (inpatient) care;
- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care, and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by Providence Health Plan and prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary.

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.2 for coverage of Outpatient Rehabilitative Services.)

4.6.4 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24 - 48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.7.

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). All Services are subject to review for Medical Necessity. Limits do not apply to Mental Health Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.)

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4. 11.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Deductible, Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits, and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

Covered Services include:

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care*.
- Newborn nurse home visits**.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit.

**Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services.

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

The services of a lay, unlicensed direct entry, certified professional, or any other unlicensed midwife are not covered.

Water births, regardless of location, will only be covered when performed by a licensed In Network Provider. No coverage will be provided for water births performed by Out of Network Providers.

Length of maternity hospital stay: Your services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery, and a minimum of 96 hours for a Caesarean delivery. You will not be discharged from the hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

Maternity support services: Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

Diabetes coverage during pregnancy: During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Network.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME)

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices, and Durable Medical Equipment (DME) are provided as shown in the Benefit Summary when required for the standard treatment of illness of injury. Providence Health Plan may authorize the purchase of an item if they determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by a Qualified Practitioner.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or more efficient model are not covered unless Medically Necessary. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.

4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan medical supply providers or under this benefit at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

Benefits are provided as shown in the Benefit Summary for the following medical appliances:

4. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
5. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
6. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
7. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.
8. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
9. Other Medically Necessary appliances, including Hearing Aids and Hearing Assistance Technology (HAT), as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck; or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 4.9.2).

4.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by Providence Health Plan.

Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us;

- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program;
- Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

An approved ABA treatment plan is subject to review by us, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

4.10.3 Substance Abuse Services

Benefits are provided for Substance Abuse at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan.

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and are described below. The Plan will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Plan.

Any visit by a person providing Services under a home health care plan, or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency. If you were hospitalized immediately prior to the commencement of home health care, the home health care plan must be initially approved by the Qualified Practitioner who was the primary provider of Services during the hospitalization.

If the above criteria are not met, NO benefits will be provided under this Plan for home health care.

Rehabilitation services provided under an authorized home health care plan will be covered as home health care Services.

Home health care benefits do NOT include:

1. Charges for mileage or travel time to and from your home;
2. Wage or shift differentials for Home Health Providers;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services include the following:

- Nursing care provided by or under the supervision of a registered nurse;

- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment (DME), medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7.

All Direct to Consumer genetic tests are considered investigational and are not covered.

4.12.2 Inborn Errors of Metabolism

The Plan will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.

4.12.5 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

- All stages of reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;

- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in 4.12.7.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services using your In-Network benefits as shown in the Benefit Summary. Covered Services include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic X-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 4.9.2(Medical Appliances). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and
6. Surgical Services.

TMJ Services are covered as shown in your Benefit Summary; limits may apply.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a Participating retail or specialty Pharmacy.

Self-administered chemotherapy is covered under your Outpatient Chemotherapy benefit. Self-administered chemotherapy is covered under your Prescription Drug benefit when that coverage results in a lower out-of-pocket expense to the Member (See section 4.14).

4.12.9 Chiropractic Manipulation

Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.10 Acupuncture

Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.11 Massage Therapy

Coverage is provided for massage therapy as stated in the Benefit Summary. To be eligible for coverage, all massage therapy Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.12 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.7 for a list of services requiring Prior Authorization.

4.12.13 Elective Sterilization

Coverage is provided, as stated below, for voluntary sterilization (tubal ligation and vasectomy).

All Covered Services must be received from Qualified Providers and Facilities. Services are covered in full and must be received from In-Network Providers.

***Please note*:** Providence Health Plan is a Catholic-sponsored health plan, and, as a matter of conscience, Providence Health & Services facilities do not offer these Services. Services are available at other In-Network facilities.

4.12.14 Hearing Loss Services

Definitions:

Cochlear Implant

Cochlear Implant means a device that can be surgically implanted under the skin in the bony area behind the ear (the cochlea) to stimulate hearing.

Hearing Aid

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries or accessory for the instrument or device, except cords.

Covered Services:
The following hearing loss services are covered under this Plan as described below. Benefits for such services are provided at the applicable benefit level for that particular type of service, as listed in your Benefit Summary.

All Covered Services must be Medically Necessary and appropriate, and prescribed, fitted, and dispensed by a licensed audiologist, hearing aid/instrument specialist, or other Qualified Practitioner.

Cochlear implants:

Cochlear implants for one or both ears, including programming, reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.

Hearing aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year.

Diagnostic & Treatment Services

Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit.

Hearing Assistance Technology:

- Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.

Limits to Hearing Loss Services
Coverage for hearing loss services are provided in accordance with state and federal law.

4.12.15 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.12.16 Biofeedback

Coverage is provided, as shown in the Benefit Summary for biofeedback to treat migraine headaches or urinary incontinence. Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person's body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

4.13.1 Covered Services

1. Covered Services for transplants are limited to Services that:
2. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;
3. Are provided at a facility approved by us or under contract with Providence Health Plan;
4. Involve one or more of the following organs or tissues:
    - Heart
    - Lung
    - Liver
    - Kidney
    - Pancreas
    - Small bowel
    - Autologous hematopoietic stem cell/bone marrow
    - Allogeneic hematopoietic stem cell/bone marrow; and
5. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel expenses are not covered for donors.)

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other Health Benefit Plan or government funding program. Covered Services for donors include:

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;

3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for pre-transplant services and post-transplant services at the applicable Inpatient Hospital Services and Outpatient Facility Services benefit.

The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.

The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for those Services, as shown in the Benefit Summary, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member's Out-of-Pocket Maximum.

4.13.5 Transplant Prior Authorization

(See also section 3.7.)

To qualify for coverage under this Plan, all transplant-related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant;
- HLA typing;
- Travel expenses;
- Pre-transplant care;

- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by Providence Health Plan;
- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions.

Prescription Drug Definition

The following are considered "Prescription Drugs":

1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription";
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Evidence Review as effective for the treatment of a particular indication.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

You have access to Providence Health Plan's nationwide broad pharmacy network as published in our pharmacy directory.

Providence Health Plan Participating Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at

www.ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.
- Participating Pharmacies may not charge you more than your Copayment or Coinsurance. Please contact Customer Service if you are asked to pay more or if you, or the pharmacy, have questions about your Prescription Drug Benefit or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drugs at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at www.ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies.)
- Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.7.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.7.4.
- Self-administered chemotherapy drugs are covered under section 4.8.14 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.1.4.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan

Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.

- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances and Deductibles.

4.14.2 Use of Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network Pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. Reimbursement is subject to your Plan's limitations and exclusions. You are responsible for any amounts above our contracted rates.

International prescription drug claims will only be covered when prescribed for emergent conditions and will be subject to your medical Emergency Services benefit and any applicable Plan limitations and exclusions.

4.14.3 Prescription Drug Formulary

The Formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives.

The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices that treat most medical conditions.

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, and must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See Section 6.1 under Claims Involving Prior Authorization and Formulary Exception.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan

will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the Formulary for your Plan, visit https://healthplans.providence.rg/members/pharmacy-resources/.

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.

If you request a brand-name drug, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

Affordable Care Act Preventive Drugs

Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our Formulary and are covered at no cost when received from Participating Pharmacies as required by the ACA. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. However, over-the-counter contraceptives do not require a written prescription pursuant to Oregon state law.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Participating Pharmacies; and
6. Opioids up to 7 days initial dispensing.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating

mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.
3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If Providence Health Plan removes a pharmacy from its network, we will notify you of this change at least 30 days in advance. Notification may be done via the online directory or letter depending on the circumstance.

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not

covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.

7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.
8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug Exclusions

In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows:

1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 16 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Over-the-counter (OTC) drugs or vitamins that may be purchased without a provider's written prescription, except as required by federal or Oregon state law;
9. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
10. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions or as required by federal or Oregon state law;
11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (*e.g.,* gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);

19. Drugs that are not FDA-approved or are designated as “less than effective” by the FDA (also known as “DESI” drugs);
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.

4.14.9 Prescription Drug Disclaimer

Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, the following are specifically excluded from coverage under this Plan.

General Exclusions:

The Plan does not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition);

The Plan does not cover:

- Charges that are in excess of the Usual, Customary, and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as covered in section 4.3.2
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.8 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 4.12.16;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.9 and 4.12.10;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;

- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;
- Recreation services, therapeutic foster care, wraparound services, emergency aid for household items and expenses; services to improve economic stability, and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;

- All services related to artificial insemination, including charges for semen harvesting and storage;
- All services and prescription drugs related to fertility preservation;
- Diagnostic testing and associated office visits to determine the cause of infertility;
- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
  - Physical examination;
  - Related laboratory testing;
  - Instruction;
  - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
  - Related supplies and prescriptions.

For the purpose of this exclusion:

- Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
- Artificial reproduction means the creation of new life other than by the natural means;

- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism; and
- Orthoptics and vision training.
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.14.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth; dental implants), except as approved by us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

6. CLAIMS ADMINISTRATION

This section explains how the Plan treats various matters having to do with administering your benefits and/or claims, including situations that may arise in which your health care expenses are the responsibility of a source other than this Plan.

6.1 CLAIMS PAYMENT

The Plan's payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly and pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to the Plan of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber's estate, unless payment to other parties is authorized in writing by you.

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after your claim has been processed. An EOB is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If your claim is denied under the Plan, Providence Health Plan will send an EOB to you with an explanation of the denial within 30 days after your claim is received. If additional time is needed to process your claim for reasons beyond Providence Health Plan's control, you will be sent a notice of delay explaining those reasons within 30 days after your claim if received. The processing will then be completed and you will be sent an EOB within 45 days after your claim is received. If additional information is needed from you to complete the processing of your claim, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you is received, Providence Health Plan will complete the processing of the claim within 30 days.

Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)

- For Prior Authorization of services that do not involve urgent medical conditions: You and your provider will be notified of Providence Health Plan's decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete their review and provide written notice of its decision to the Member and the provider. If the information is not received within 15 days, the request will be denied.

- **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.
- **For Formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.

Claims Involving Concurrent Care Decisions

If an ongoing course of treatment for you has been approved under the Plan and it is determined through Concurrent Review procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request a reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. You will then be notified of Providence Health Plan's reconsideration decision within 24 hours after your request is received.

6.1.1 Timely Submission of Claims

The Plan will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if Providence Health Plan receives documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon insurance Division's administrative rule setting standards for prompt payment. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

6.1.2 Right of Recovery

The Plan has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from the Plan under any contract.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as

dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and may reduce the benefits payable so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If the Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If the Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If the Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because the Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

6.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
        a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
            i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or

ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
      - The Plan covering the Custodial parent, first;
      - The Plan covering the spouse of the Custodial parent, second;
      - The Plan covering the non-custodial parent, third; and then
      - The Plan covering the Dependent spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:
   i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.
   ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a

Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than would have paid had This Plan been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, benefits may be reduced so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give us any facts Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.2.6 Right of Recovery

If the amount of the payments made by This Plan is more than what should have paid under this COB section, This Plan may recover the excess from one or more of the persons This Plan paid or for whom This Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions.

In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B.

When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare.

Counting individuals for the Employer size:

- Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.
- Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member's policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the

terms of this section will be a basis for the Plan to deny any claims for benefits arising from the condition or to terminate the Member's coverage under this Plan as specified in section 9.4. In addition, you or the Member must execute and deliver to the Plan and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and the Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the Plan or the Member. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member's heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which the Member or the Member's heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, the Plan will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Plan.

If the Plan makes claim payments on any Member's behalf for any condition for which a third party is responsible, the Plan is entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery.

"Subrogation" means that the Plan may collect directly from the third party to the extent the Plan has paid for third-party liabilities. Because the Plan has paid for the Member's injuries, the Plan, rather than the Member, is entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify the Plan in writing of any terms or conditions offered in settlement and must notify the third party of the Plan's interest in the settlement established by this provision.

To the maximum extent permitted by law, the Plan is subrogated to the Member's rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member's name, and has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

To accomplish this process, the Plan needs detailed information from you or from the Member. A questionnaire will be sent to the Member for this information. It should be completed and returned to Providence Health Plan as soon as possible to minimize any claim review delay. If you or the Member has any questions or concerns regarding the questionnaire, please contact Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason the Plan is not paid directly by the third party, the Plan is entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and the Plan may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by the Plan, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, the Plan is entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. The Plan is entitled to recover up to the full value of the benefits provided by the Plan for the condition, calculated using the Plan's UCR charges for such Services, less the Plan's pro-rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. The Plan is entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Plan, the Member acknowledges the Plan's first priority to this repayment and assigns to us any benefits the Member may have from other sources. The Member must cooperate fully with the Plan and Providence Health Plan in recovering amounts paid by the Plan. If any Member seeks damages against the third party for the condition and retains an attorney or other agent for representation in the matter, that Member agrees to require the Member's attorney or agent to reimburse the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan directly from any settlement or recovery. The Plan may withhold benefits for the Member's condition until a signed copy of this agreement is delivered to the Plan. The agreement must remain in effect and the Plan may withhold payment of benefits if, at any time, the Member's confirmation of the obligations under this section should be revoked. While this document is not necessary for the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that the Plan would otherwise be required to pay under this Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, the Plan is not required to provide coverage for continuing treatment until the Member proves to the Plan's satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. The Plan will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using the Plan's UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. The Plan is entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate you for your medical expenses, regardless of any allocation of proceeds in any settlement document that the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled Family Member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 6.3.2 and 6.3.3 above are modified as provided below.

Before the Plan will be entitled to recover from under a settlement or recovery, you or your enrolled Family Member must first have received full compensation for your injuries. The Plan's entitlement to recover will be payable only from the total amount of the recovery in excess of the amount that fully compensates for the injured person's injuries.

The Plan will not deny or refuse to provide benefits otherwise available to you or your enrolled Family Member because of the possibility that a third party recovery may potentially be available against the person who caused the accident or out of motor vehicle liability or underinsurance coverage.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Your Customer Service representative is available to provide information and assistance. You may call or meet with Providence Health Plan at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;

- Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an internal review. You may request review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or grievance with Providence Health Plan. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or Appeal and Providence Health Plan will consider that information in the review process.
- You can be represented by anyone of your choice at all levels of Appeal.

Request for Claim/Appeal File and Additional Information:

- You can, upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to our decision at any time before, during, or after the appeal process. This includes the specific internal rule, guidelines, protocol, or other similar criterion relied upon to make the Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable.
- You also have the right to request free of charge, at any time, the diagnostic and treatment codes and their meanings that are the subject of your claim or appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.

If you receive the services that were denied in the Adverse Benefit Determination, and if the Adverse Benefit Determination is upheld by internal or external review, you will be financially responsible for any benefits paid by the Plan for such services.

To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service by. We will acknowledge all non-urgent pre-service and post-service Grievance and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines as noted below.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling a Customer Service representative at 503-574-7500 or 800-878-4445 outside the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. Providence Health Plan will let you know by phone and letter if your case qualifies for an expedited review. If it does, you will be notified of the decision within 72 hours of receiving your request.

Grievances and Appeals Involving Concurrent Care Decisions: If Providence Health Plan has approved an ongoing course of treatment for you and determines through medical management procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary, you may request an external review by an IRO. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary.**

The Plan pays for all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal or requests for External Review to 503-574-8757 or 800-396-4778, or you may hand deliver it *(if mailing, use only the post office box address listed above)* to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

If you decline coverage or fail to enroll when you first become eligible, the next earliest time you may enroll is the next occurring Open Enrollment Period.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

Clackamas County will provide an Open Enrollment Period each Plan Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Plan Year for which they enroll.

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made over the phone by calling Customer Service or by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

In instances where an Eligible Family Dependent of a Subscriber qualifies for a "special enrollment period," the Subscriber and the Eligible Family Dependent may:

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) because of other health coverage and you lose that other coverage, the Plan will provide a "special enrollment period" for you and/or your Eligible Family Dependent if:

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and
b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and
c) Such coverage:
    - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
    - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
        1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or

2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or
3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

Effective Date: Coverage under this Plan will take effect on the first day after the other coverage ended.

8.3.2 New Dependents

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.

The "special enrollment period" shall be a period of 60 days and begins on the later of:

- the date Dependent coverage is made available under this Plan; or
- the date of the marriage, birth, or adoption or placement for adoption.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

If you or your Eligible Family Dependent were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent

becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children's Health Insurance Program (CHIP)-sponsored arrangement, the Plan will provide a "special enrollment period" for you and your Family Member(s) if you request enrollment within 60 days after the date of entitlement.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3

For the Subscriber, a leave of absence granted under the federal Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

Termination of Member coverage under this Plan will occur on the earliest of the following dates:

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County of any changes in eligibility including the lack of eligibility of a Family Member. Coverage will not continue beyond the last date of eligibility, regardless of the lack of notice to Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered Dependents the benefits paid as a result of such wrongful activity. Providence Health Plan will provide all affected Plan participants with 30 days' notice before rescinding your coverage.

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated because you have engaged in fraudulent, dishonest or threatening behavior, such as:

1. You have filed a false claim with the Plan;
2. You willfully fail to provide information or documentation required to be provided under this Plan or knowingly provide incorrect or incomplete information;
3. You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County reserves the right at any time to terminate or amend in whole or part any of the provisions of the Plan or any of the benefits provided under the Plan. Any such termination or amendment may take effect retroactively or otherwise. In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction and no payments scheduled to be made on or after such effective date will result in any liability to the Plan or Clackamas County.

10. CONTINUATION OF GROUP MEDICAL BENEFITS

If you become ineligible for coverage under this Plan you may, under certain circumstances, continue group coverage. There are specific requirements, time frames and conditions that must be followed in order to be eligible for continuation of group coverage and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that applies to most Employers with 20 or more employees. Some Employers, such as church groups and state agencies, may be exempt from COBRA. The law requires that Employers subject to COBRA offer Employees and/or their Dependents continuation of medical and dental coverage in certain instances where there is a loss of group coverage.

10.1.1 Subscriber's Continuation Coverage

A Subscriber who is covered under this Plan may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

A Spouse or Domestic Partner who is covered under this Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the Subscriber and the Spouse;
- Termination of the domestic partnership; or
- The Subscriber becomes covered under Medicare.

10.1.3 Dependent's Continuation Coverage

A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours;
- The Subscriber's divorce or legal separation;
- Termination of the domestic partnership;
- The Subscriber becomes covered under Medicare; or
- The child ceases to qualify as an Eligible Family Member under this Plan.

A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 Notice Requirements

A Family Member's coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs or a child loses Dependent status under this Plan. **Under COBRA, you or your Family Member has the responsibility to notify Clackamas County if one of these events occurs.** Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When Clackamas County receives notification of one of the above "qualifying" events, you will be notified that you or your Family Member, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, your right to elect continuation coverage under this Plan will be lost.

10.1.5 Type of COBRA Continuation Coverage

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

10.1.6 COBRA Election Rights

A Subscriber or their Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

10.1.7 COBRA Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay the premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.

10.1.8 Length of COBRA Continuation Coverage

18-Month Continuation Period

When coverage ends due to a Subscriber's termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the Subscriber and all covered Family Members will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

29-Month Continuation Period

If a qualified beneficiary is disabled, continuation coverage for that qualified beneficiary and their covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides Clackamas County with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days.

36-Month Continuation Period

If a Spouse, Domestic Partner or Dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The Subscriber's death;
- The Subscriber's eligibility for Medicare;
- Divorce or legal separation;
- Termination of the domestic partnership; or
- A child becomes ineligible for Dependent coverage.

10.1.9 Extension of Continuation Period

If a second qualifying event occurs during the initial 18- or 29-month continuation period (for example, the death of the employee, divorce, or child loses status as an Eligible Family Member under the Plan), coverage for a qualified beneficiary may be extended up to 36 months. However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a Spouse or Dependent child has continuation coverage due to the employee's termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee's Medicare entitlement date.

10.1.10 Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the Pension Benefit Guaranty Corporation (PBGC), to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of sixty-five percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY caller may call toll-free at 866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

10.1.11 When COBRA Continuation Coverage Ends

COBRA Continuation coverage will end automatically for you and your Family Members when any of the following events occurs:

- Clackamas County no longer provides health coverage to any employees;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary employee, spouse or dependent child) later becomes covered under another health plan;
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. Providence Health Plan wants you to have a positive experience, and are ready to help in any way.

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and In-Network Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS)

The following information applies to Members (participants) who are covered by a plan that is not subject to ERISA.

As a participant in Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, provided you request it in writing and reasonably describe the information.
    - You may obtain copies, subject to paying a reasonable copying charge.
    - You are entitled to know to whom we may have disclosed any such information.
    - You are entitled to correct any errors in the information.

2. Continue group health coverage
    - Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.1.
3. Enforce your rights

    If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

    As more fully described in section 7, the Plan offers a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (IRO) decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2.

    Member's sole right of Appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between the Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A child of an Eligible Employee will be enrolled in the Plan as required by a qualified medical child support order. The procedures and rules regarding this enrollment are described in this section.

12.1 DEFINITIONS

For purposes of this section, the following definitions shall apply:

"Alternate Recipient" means any child of an employee who is recognized under an Order as having a right to enrollment under the Plan with respect to such employee.

An "Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (or through an administrative process established under a state law which has the effect of a court order) which:

- Provides for child support with respect to a child of an employee under the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or
- Enforces a state law relating to medical child support with respect to the Plan.

A "Qualified Medical Child Support Order" or "QMCSO" means an Order:

- Which creates or recognizes the existence of an Alternate Recipient's right to receive, or assigns to an Alternate Recipient the right to receive, benefits for which an employee or beneficiary is eligible under the Plan; and
- With respect to which Clackamas County has determined satisfies the QMSCO standards set forth below.

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section.

"Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County will promptly notify the employee and each Alternate Recipient identified in such Order of the receipt of such Order, and will further furnish them each with a copy of these Procedures. If the Order or any accompanying correspondence identifies a Designated Representative, then copies of the acknowledgment of receipt notice and these Procedures will also then be provided to such Designated Representative.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County will determine whether the Order satisfies the QMCSO standards described below so as to constitute a QMCSO, and shall thereupon notify the employee, each Alternate Recipient, and any Designated Representative of such determination.

An Order will not be deemed to be a QMCSO unless the Order:

(a) Clearly specifies:
    1. The name and last known mailing address (if any) of the employee and of each Alternate Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);
    2. Either a reasonable description of the type of coverage to be provided under the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
    3. The period to which the Order applies.

(b) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

If an Order contains inconsistencies or ambiguities that might pose a risk of future controversy or liability to the Plan, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to Clackamas County will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been voluntary enrolled in the Plan by the employee as a dependent of such employee, including in regard to the payment by the employee for dependent coverage under the Plan. The amount of any required contributions to be made by the Employee for coverage under the Plan will be determined on the basis of the Alternate Recipient being treated as the employee's covered dependent. Any additional required contribution attributable to the coverage of the Alternate Recipient will not be separately charged. Rather, the full amount of the required contribution shall be paid by the employee in accordance with the payroll deduction or other procedures of the Plan as pertaining to the employee.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the employee. Rather, such reimbursement will be paid either to the Alternate Recipient, or to the custodial parent or legal guardian of such Alternate Recipient. However, if the name and address of a State or agency official has been substituted in the Order for that of the Alternate Recipient, then the reimbursement will be paid to such named official.

12.7 STATUS OF ALTERNATE RECIPIENT

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the Employee under the Plan to which the Order pertains.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County receives an appropriately completed National Medical Support Notice (a "National Notice") issued pursuant to the Child Support Performance and Incentive Act of 1998 in regard to an employee who is a non-custodial parent of a child, and if the National Notice is determined by Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, shall within forty (40) business days after the date of the National Notice notify the State agency issuing the National Notice of the following:

(a) Whether coverage of the child at issue is available under the terms of the Plan, and if so, as to whether such child is covered under the Plan; and
(b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the State or agency official acting on behalf of the child) to effectuate the coverage under the Plan.

Clackamas County shall within such time period also provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the Plan, upon receipt of a National Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as in effect immediately before receipt of such National Notice.

13. GENERAL PROVISIONS

13.1 CONFLICTS OF PROVISIONS

In the event that one or more provisions of this document conflict with one or more provisions of any other plan document, the provisions of this document, as from time to time amended, shall control.

13.2 CONTROLLING STATE LAW

To the extent not preempted by federal laws, the laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the Plan.

13.3 DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, the Plan will pay only under the provision allowing the greater benefit. This may require a recalculation based upon both the amounts already paid and the amounts due to be paid. The Plan has NO liability for benefits other than those this Plan provides.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 GENDER AND NUMBER

Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

13.6 HEADINGS

All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth there under.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2. If ERISA does not apply (see section 11.2) the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND PROVISIONS

The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other employee benefits plan maintained by Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Plan. Neither Clackamas County nor Providence Health Plan will have any liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Providence Health Plan. They will assist you in understanding and complying with the terms of the Plan.

13.10 MEMBERSHIP ID CARD

The membership ID card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

13.11 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is nontransferable.

13.12 NO GUARANTEE OF EMPLOYMENT

Neither the maintenance of the Plan nor any part thereof shall be construed as giving any employee covered hereunder any right to remain in the employ of Clackamas County. No shareholder, director, officer, or employee of Clackamas County in any way guarantees to any Member or beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

13.13 NO RECOURSE FOR ACTS OF PROVIDERS

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. Neither Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 NON-WAIVER

No delay or failure when exercising or enforcing any right under this Plan shall constitute a waiver or relinquishment of that right, and no waiver or any default under this Plan shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Plan shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Providence Health Plan, P.O. Box 3125, Portland, OR 97208.

13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly by an Out-of-Network Provider and you pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to Providence Health Plan of the payment. Payment will be made to the Member, subject to written notice of claim, or, if deceased, to the Member's estate, unless payment to other parties is authorized in writing by you. See section 6.1.1 regarding timely submission of claims.

13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. Providence Health Plan, in their discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner considered advisable, to be expended for the person's benefit. PHP's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by Clackamas County and Providence Health Plan.

13.18 PHYSICAL EXAMINATION AND AUTOPSY

When reasonably required for purposes of claim determination, the Plan Sponsor shall have the right to make arrangements for the following examinations, at Plan expense, and to suspend the related claim determination until Providence Health Plan has received and evaluated the results of the examination:

- A physical examination of a Member; or
- An autopsy of a deceased Member, if not forbidden by law.

13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Members, by acceptance of the benefits of this Plan, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or their designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with Providence Health Plan any information relating to any condition for which benefits are claimed under this Plan. Providence Health Plan may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf. If you do not consent to the release of records or to discussions with providers, Providence Health Plan will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

13.20 REQUIRED INFORMATION TO BE FURNISHED

Each Member must furnish to Providence Health Plan such information as they consider necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Member of such true, full and complete information as may be requested.

13.21 RIGHT OF RECOVERY

Providence Health Plan, on behalf of the Plan, has the right, upon demand, to recover payments in excess of the maximum benefits specified in this Plan or payments obtained through fraud, error, or duplicate coverage. If reimbursement is not made to the Plan, Providence Health Plan is authorized by Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 SEVERABILITY

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

13.23 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

- Payment for benefits with respect to a Member under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Member, as required by a State Medicaid Plan;
- The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's enrollment as a Member or beneficiary in the Plan, or in determining or making any payments for benefits of the individual as a Member in the Plan; and
- Payment for benefits under the Plan shall be made to a state in accordance with any state law which provides that the state has acquired the rights with respect to a Member for items or services constituting medical assistance under a State Medicaid Plan.

For purposes of the above, a "State Medicaid Plan" means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

13.24 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees entering into or returning from service in the armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In general, USERRA provides that:

(a) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County to perform services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents) on a self-pay basis. The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 10 Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:
    1. The end of the 24-month period beginning on the date on which the employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan sponsored by the Employer with administrative services provided by Providence Health Plan. The funding for the benefits is derived from the funds of the Employer. The Plan is not insured.

This Summary Plan Description constitutes the written instrument under which the Plan is maintained and this document replaces all previous Summary Plan Descriptions. The rights of any person whose employment has terminated, and the rights of such person's covered dependents, will be determined pursuant to the terms of the Plan as in effect on the date such employment terminated, except as may otherwise be specifically provided under the Plan.

14.2 PLAN INFORMATION

Plan Name: Clackamas County General County Employees Personal Option Plan
Plan No. 10112
Employer ID No. 936002286

14.3 PLAN DATES

The effective date of the Plan is January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
800-878-4445

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer shall be responsible for all fiduciary functions under the Plan except insofar as any such authority or responsibility is assigned by or pursuant to the Plan to another named fiduciary, or is delegated to another fiduciary by the Employer. The Employer has the discretionary authority to determine eligibility for benefits under the Plan and to interpret the terms of the Plan, unless it has delegated that authority as permitted by the Plan. In the event of such delegation, Providence Health Plan's determinations on the meaning of Plan terms may not be overturned unless found by a court to have been arbitrary and capricious. The allocation of administrative duties and the delegation of discretionary authority for the Plan is specified in the Administrative Services Agreement that has been executed by the Employer and Providence Health Plan.

14.7.1 Complete Allocation of Fiduciary Responsibilities

This section is intended to allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each. The performance of such responsibilities will be deemed a several and not a joint assignment. None of such responsibilities nor any other responsibility is intended to be shared by two or more of them unless such sharing will be provided by a specific provision of the Plan. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two will not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction will be deemed to be its sole responsibility, and the responsibility of the one receiving such direction will be to follow it insofar as such direction is on its face proper under the Plan and applicable law.

14.8 ENGAGEMENT OF ADVISORS

The Employer may employ on behalf of the Plan one or more persons to render advice with regard to any responsibility it may have under the Plan. Toward that end, the Employer may appoint, employ and consult with legal counsel, actuaries, accountants, investment consultants, physicians or other advisors (who may be counsel, actuaries, accountants, consultants, physicians or other advisors for the Employer) and may also from time to time utilize the services of employees and agents of the Employer in the discharge of their respective responsibilities.

14.9 INDEMNIFICATION

The Employer will indemnify its employees for any liability or expenses, including attorneys' fees, incurred in the defense of any threatened or pending action, suit or proceeding by reason of their status as a fiduciary with respect to the Plan, to the full extent permitted by law.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

The Employer reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the Plan, or any document forming part of the Plan.

14.10.2 Manner of Action

Any amendment or termination of the Plan or any part of the Plan shall be made by an instrument in writing reflecting that such change has been authorized by the Employer. Any such amendment or termination shall be effective as of the date specified in said instrument, or, if no date is so specified, as of the date of execution or adoption of said instrument. An amendment may be effected by establishment, modification, or termination of the Plan by appropriate action of the Employer. Any such amendment or termination may take effect retroactively or otherwise. An instrument regarding the establishment, modification or termination of the Plan which is executed by the Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 Effect on Benefits

Claims incurred before the effective date of a Plan change or termination will not be affected. Claims incurred after Plan changes will be covered according to the provisions in effect at the time the claim is incurred. Claims incurred after the Plan is terminated will not be covered. You will not be vested in any Plan benefits or have any further rights, subject to applicable law.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan may disclose de-identified summary health information to the Employer for purposes of modifying, amending or terminating this Plan. In addition, Providence Health Plan may disclose protected health information (PHI) to the Employer in accordance with the following provisions of this Plan as established by the Employer:

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) The Employer shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
(i) The Employer shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
(j) The Employer shall provide for adequate separation between the Employer and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of the Employer:
    1. Directors of Human Resources;
    2. Benefit Managers;
    3. Benefit Analysts;
    4. Benefit Specialists; and
    5. Internal Auditors, when performing Health Plan Audits.

Further, the Employer shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for the Employer with regard to this Plan. In addition, the Employer shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

14.11.2 Security

In accordance with the security standards of the Health Insurance Portability and Accountability Act (HIPAA), the Employer shall:

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

The following are definitions of important capitalized terms used in this Summary Plan Description.

Adverse Benefit Determination
See section 7.

Alternative Care Provider
Alternative Care Provider means a naturopath, chiropractor, acupuncturist, or massage therapist who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the documents with that title that are part of your Plan and summarize the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Chemical Dependency
Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Substance Abuse does not mean an addiction to, or dependency on tobacco, tobacco products or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County General County Employees Personal Option Plan
Clackamas County General County Employees Personal Option Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant
See section 4.12.14.

Coinsurance
Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

Confinement
Confinement means being a resident patient in a Hospital, Skilled Nursing Facility or Qualified Treatment Facility for at least 15 consecutive hours. Successive Confinements are considered to be one Confinement if:

1. Due to the same injury or illness; and
2. Separated by fewer than 30 consecutive days when you are not confined.

Contribution
Contribution means the monetary amount that an Employee is required to contribute as a condition to coverage under the Plan. Specific Contribution amounts are available from your Human Resources office.

Copayment
Copayment means the dollar amount that you are responsible for paying to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary.

Cosmetic Services
Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

1. Listed as a benefit in the Benefit Summary and in section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; and
4. Provided to you while you are a Member and eligible for the Service under this Plan.

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care

Custodial Care means Services that:

1. Do not require the technical skills of a licensed nurse at all times;
2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
3. Are not likely to improve your medical condition.

Such Services will still be considered Custodial Care even if:

1. You are under the care of a physician;
2. The Services are prescribed by a Qualified Practitioner;
3. The Services function to support or maintain your condition; or
4. The Services are being provided by a registered nurse or licensed practical nurse.

Deductible

See section 3.13.1.

Dependent

Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.

Domestic Partner

A Domestic Partner means either of the following:

1. An Oregon Registered Domestic Partner is a person who:
    - Is at least 18 years of age;
    - Has entered into a Domestic Partnership with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
2. A domestic partner who is not an Oregon Registered Domestic Partner is a person at least 18 years of age who:
    - Shares a close personal relationship with a subscriber such that each is responsible for each other's welfare;
    - Is the subscriber's sole domestic partner;

- Is not married to any person and has not had another domestic partner within the prior six months;
- Is not related by blood to the subscriber as a first cousin or nearer;
- Shares with the subscriber the same regular and permanent residence, with the current intention of doing so indefinitely;
- Is jointly financially responsible with the subscriber for basic living expenses such as food and shelter;
- Was mentally competent to consent to contract when the domestic partnership began; and
- Has provided the required employer documentation establishing that a domestic partnership exists.

Note: All provisions of the Plan that apply to a spouse shall apply to a Domestic Partner.

Durable Medical Equipment (DME)
Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

E-mail Visit
E-mail visit (electronic provider communications) means a consultation through e-mail with an In-Network Provider that is, in the judgment of the In-Network Provider, Medically Necessary and appropriate and involves a significant amount of the In-Network Provider's time. An E-mail visit must relate to the treatment of a covered illness or injury (see also section4.3.3).

Effective Date of Coverage
Effective Date of Coverage means the date upon which coverage under this Plan commences for a Member.

Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee
Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Personal Option General County Employees, COBRA-participants and Non Medicare Eligible Early Retirees.
3. Work Hours: Regularly scheduled for at least 20 hours per week (18.75 hours per week for Job Share). Not applicable to COBRA and Early Retiree.

4. Eligibility Waiting Period: Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA and/or Portability provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

1. Eligible Family Dependent means:
2. The legally recognized Spouse or Domestic Partner of a Subscriber;
3. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

The limiting age for each Dependent child is 26 and such children shall become ineligible for coverage on the last day of the month in which their 26th birthday occurs.

A covered Dependent child who attains the limiting age remains eligible if the child is:

1. Developmentally or physically disabled;
2. Incapable of self-sustaining employment prior to the limiting age; and
3. Unmarried.

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under this Plan, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age. Thereafter, Providence Health Plan may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

Endorsement
Endorsement means a document that amends and is part of this Plan.

Essential Health Benefits
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

Exclusion
Exclusion means an item or service that is not a Covered Service under the Plan.

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In

determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are:

- Approved by the appropriate governmental regulatory body;
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient provider in the United States;
- Reviewed and supported by national professional medical societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. Providence Health Plan will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon request.

Family Member
Family Member means a Dependent who is properly enrolled in and entitled to Covered Services under this Plan.

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

Health Benefit Plan
Health Benefit Plan means any Hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple Employer welfare arrangement or other benefit arrangement defined in the federal Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.14.

Hearing Assistance Technology
See section 4.12.14.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Provider
Home Health Provider means a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed

by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

Hospital

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home, Skilled Nursing Facility, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Substance Abuse or Mental Health disorders.

In-Network

In-Network means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services that are provided by an In-Network Provider.

In-Network Provider

In-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

Ineligible Person

Ineligible Person means any person who does not qualify as a Member under this Plan.

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

Medically Necessary

Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by Providence Health Plan.

The criteria are based on the following principles:

1. Covered Services are determined to be Medically Necessary if they are health care services or products that a Qualified Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing, preventing, or treating illness (including mental illness), injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice;
    i. Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Qualified Practitioner specialty society recommendations, the views of Qualified Practitioners practicing in relevant clinical areas, and any other relevant factors;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the Member's medical condition;
c. Not primarily for the convenience of the Member or Qualified Practitioner; and
d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's illness, injury or disease.

Prudent Clinical Judgment: The "prudent clinical judgment" standard of Medical Necessity ensures that Qualified Practitioners are able to use their expertise and exercise discretion, consistent with good medical care, in determining the Medical Necessity for health care services to be provided to each Member. Covered Services may include, but are not limited to, medical, surgical, diagnostic tests, substance abuse treatment, other health care technologies, supplies, treatments, procedures, drug therapies or devices.

Member
Member means a Subscriber or Eligible Family Dependent, who is properly enrolled in and entitled to Services under this Plan.

Mental Health
Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), such as but not limited to major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and substance use disorder.

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, during which Eligible Employees are given the opportunity to enroll themselves and their Dependents under the Plan for the upcoming Plan Year, subject to the terms and provisions as found in this Summary Plan Description.

Out-of-Network
Out-of-Network means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services provided by Out-of-Network Providers.

Out-of-Network Provider
Out-of-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital, Skilled Nursing Facility, or

Pharmacy that does not have a written agreement with Providence Health Plan to participate as a health care provider for this Plan.

Out-of-Pocket Maximum
See section 3.12.2.

Outpatient Surgical Facility
Outpatient surgical facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Pharmacy
Participating Pharmacy means pharmacy that has signed a contractual agreement with Providence health Plan to provide medications and other Services at special rates. There are four types of Participating Pharmacies:

1. Retail: A Participating Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
3. Specialty: A Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
4. Mail Order: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Plan
Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary and any Endorsements, amendments and addendums that accompany this document.

Plan Administrator
Plan Administrator means the "Administrator" or "Plan Administrator" as those terms are defined under ERISA and shall refer to the current or succeeding person, committee, partnership, or other entity designated as such by the terms of the instrument under which the Plan is operated, or by law. Regardless of the terms of the instrument under which the Plan is operated, Providence Health Plan is not the Plan Administrator.

Plan Year
Plan Year means a 12-month time period beginning January 1st and ending December 31st.

Primary Care Provider
Primary Care Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician who agrees to be responsible for the Member's continuing medical care by serving as case manager. Members may also choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a

certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

(Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the Provider Directory online or call Customer Service.)

Prior Authorization

Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.7.

Prior Authorized determinations are not a guarantee of benefit payment unless:

- A determination that relates to benefit coverage and medical necessity is obtained no more than 30 days prior to the date of the Service; or
- A determination that relates to eligibility is obtained no more than five business days prior to the date of the Service.

Providence Health Plan

Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon and Washington that serves as the claims administrator with respect to this Plan.

Qualified Practitioner

Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, naturopath, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility

Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery

Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic

Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket, or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified as a "Skilled Nursing Facility" by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Spouse
Spouse means an individual who is legally married to the Subscriber in accordance with the laws of the country or state of celebration.

Subscriber
Subscriber means an employee or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

Summary Plan Description (SPD)
Summary Plan Description (SPD) means the description of the Plan as contained in this document, and includes the provisions of any Benefit Summary, any Endorsements, amendments and addendums that accompany this document, and those policies maintained by Providence Health Plan which clarify any of those documents.

Termination Date of Coverage
Termination Date of Coverage means the date upon which coverage under this Plan ends for a Member. No coverage under the Plan will be provided beyond the Termination Date of Coverage.

Urgent Care
Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.

Urgent Care Covered Services are provided when your medical condition meets the guidelines for Urgent Care that have been established by Providence Health Plan. Covered Services do **NOT** include Services for the inappropriate use of an Urgent Care facility, such as: services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with In-Network Providers for that Service. UCR charges will never be less than Providence Health Plan's negotiated fees.

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Virtual Visit

Virtual Visit means a visit with an In-Network Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife, or licensed direct entry midwife practicing within the applicable lawful scope of practice.

16. NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

لحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا. اتصل بالرقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711 (TTY:).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید تسهیلات زبانی رایگان برای شما فراهم می باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

ADOPTION OF THE SUMMARY PLAN DESCRIPTION AS THE PLAN DOCUMENT

Adoption

On the date shown, below, the Plan Sponsor hereby adopts this Summary Plan Description and the Benefit Summaries, Endorsements and amendments which are incorporated by reference, as the Plan Document of the Clackamas County's self-funded Employee Health Benefit Plan, Clackamas County General County Employee Personal Option Plan. This document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for Clackamas County's Eligible Employees and Eligible Family Dependents. Those benefits are described in this Summary Plan Description.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed, effective as of January 1, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); or one of our Sales representatives at 503-574-6300 or 877-245-4077, 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

Clackamas Co GCE Personal Option SPD
Effective January 01, 2021
Administered by Providence Health Plan

2021 Summary Plan Description

Peace Officers Association

Open Option Grandfathered

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County has contracted with Providence Health Plan to process claims and provide customer service to Plan Members. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Mail order prescription drug services	ProvidenceHealthPlan.com
Medical, Mental Health, and Chemical Dependency Prior Authorization requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION OPEN OPTION GRANDFATHERED PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us" or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
  - Our Providence Signature Network of In-Network Providers;
  - Providence Health Plan's national network of In-Network Providers; and
  - Out-of-Network Providers.
- With this Plan, Members will generally have lower out-of-pocket expenses when obtaining Covered Services from In-Network Providers. Members may, however, obtain most Covered Services from Out-of-Network Providers, but that option will result in higher out-of-pocket expenses. Please see section 3 and your Plan Benefit Summary for additional information.
- Some Services are covered only under your In-Network benefits:
  - Web-direct Visits, as specified in section 4.3.2;
  - E-mail Visit Services, as specified in section 4.3.3;
  - Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7;
  - Tobacco Use Cessation Services, as specified in section 4.1.8;
  - Human Organ/Tissue Transplant Services, as specified in section 4.13; and
  - Any item listed in your Benefit Summary as "Not Covered" Out-of-Plan.
- Coverage is provided in full for most preventive Services when those Services are received from specified In-Network Providers. See your Benefit Summary for additional information.
- All Members are encouraged to choose a Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of In-Network Providers in our Service Area and our national In-Network Providers is available at ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in Plan documents. You should read the provisions, limitation and exclusions before seeking Covered Services because not all health care services are covered by this Plan.

- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan's policies.

1.2 GRANDFATHERED PLAN NOTICE

This Employer Group believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of PPACA that apply to other Plans, for example, the requirement for the coverage of certain preventive health care services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of the lifetime maximum benefit.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or human resources department.

Non-ERISA Plans: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. Our goal is to help improve the health status of individuals in the communities in which we serve. This booklet contains important information about the health plan coverage offered to Clackamas County Peace Officer Association Employees and their Dependents.

2.1 CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION OPEN OPTION GRANDFATHERED PLAN

Your Plan allows you to receive Covered Services from In-Network Providers through what is called your In-Plan benefit. You also have the option to receive most Covered Services from Out-of-Network Providers through what is called your Out-of-Plan benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from In-Network Providers. Also, In-Network Providers will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services listed in section 3.5 are Prior Authorized by Providence Health Plan before treatment is received.

It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is an In-Network Provider and whether or not the health care is a Covered Service even if you have been directed or referred for care by an In-Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit our Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, before you make an appointment. You can also call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

Whenever you visit a Provider:

- Bring your Providence Health Plan Member ID Card with you.
- Be prepared to make a Copayment at the time of visit if the office visit is subject to a Copayment.
- If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be able to pay for what you owe at the time of your visit. Your provider's office will send you a bill for what you owe later. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and bill or credit you for the balance later.

2.2 SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains important information about the health plan coverage offered to employees of Clackamas County. It is important to read this Summary Plan Description carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 15. If you need additional help understanding anything in this Summary Plan Description, please call Customer Service at 503-574-7500 or 800-878-4445. See section 2.3 for additional information on how to reach Customer Service.

This Summary Plan Description is not complete without your:

- **Clackamas County Peace Officers Association Open Option Grandfathered Plan Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, Copayments and Coinsurance for Covered Services and also provide other important information.
- **Provider Directory** which lists In-Network Providers, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need detailed information for a specific problem or situation, contact your Employer or Customer Service.

2.3 CUSTOMER SERVICE

We want you to understand how to use your Providence Health Plan benefits and to be satisfied with your health plan coverage. Customer Service is available to assist you in understanding your benefits and resolving any problems you may have, including:

- Specific benefit or claim questions.
- Questions or concerns about your health care or service.

Contacting Providence Customer Service
Customer Service representatives are available by phone from 8 a.m. to 5 p.m., Monday through Friday, (excluding holidays). **Please have your Member ID Card available when you call:**

- **Members in the Portland-metro area, please call 503-574-7500.**
- **Members in all other areas, please call toll-free 800-878-4445.**
- **Members with hearing impairment, please call the TTY line 711**

You may **access claims and benefit information 24 hours a day, seven days a week** online through your myProvidence account.

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Summary Plan Description and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768.

2.5 YOUR MEMBER ID CARD

Each Member of Providence Health Plan receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member number and group number
- Important phone numbers

The Member ID Card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your Member ID Card, and pay your Copayment or Coinsurance.

Please keep your Member ID Card with you and use it when you:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse Customer Service.
- Call or correspond with Customer Service.
- Call Providence nurse advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.

2.6 PROVIDENCE NURSE ADVICE LINE

503-574-6520; toll-free 800-700-0481; TTY 711

The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6, for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching
Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for tobacco-use cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

Quit for Life can be reached at 866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See Registering for a myProvidence account, section 2.4, for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America

Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services for Providence Health Plan members. Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program. Please have your Providence Health Plan Member ID card ready, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information," we mean information that identifies you as an individual (such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain their medical records from their provider. Call your physician's or provider's office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represent a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan.

Providence Health Plan may disclose a Member's PHI to an employer or any agent of the Employer if the disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it.

3. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Primary Care Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing.

This section describes how to use this Plan and how benefits are applied. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered using your In-Plan benefit, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is an In-Network Provider even if you have been directed or referred for care by an In-Network Provider.

3.1.1 Nationwide Network of In-Network Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services when using In-Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing an In-Network Provider

To choose an In-Network Provider, or to verify if a provider is an In-Network Provider, please refer to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

Advantages of Using an In-Network Provider

- Your In-Network Provider will work with Providence Health Plan to arrange for any Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.5.
- In most cases when you use In-Network Providers, higher benefit levels will apply and your out-of-pocket expenses will be reduced.
- You will have a wide variety of high quality In-Network Providers to help you with your health care needs.

So remember, it is to your advantage to meet your health care needs by using an In-Network Provider, including an In-Network Primary Care Provider, whenever possible.

3.1.3 Indian Health Services Providers

Native American Indian and Alaskan Native Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from an In-Network Provider. For a list of IHS facilities, please visit the IHS website at www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend that upon joining Providence Health Plan you and each of your Family Members choose an In-Network Primary Care Provider as soon as possible.

3.2.1 Primary Care Providers

A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider.

Primary Care Providers provide preventive care and health screenings, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Primary Care Providers offer maternity care and minor outpatient surgery as well.

IMPORTANT NOTE: In-Network Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our In-Network Providers with the specialties listed above are In-Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated In-Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend that you choose a Primary Care Provider from our Provider Directory, available online, for each covered Family Member. Call the provider's office to make sure they are accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

- What are the office hours?
- How can I get medical advice after hours?
- What do I do in an emergency?

Let your Primary Care Provider know if you are under a specialist's care as well as if you are currently taking any ongoing prescription medications.

3.2.4 Changing Your Primary Care Provider

You are encouraged to establish an ongoing relationship with your Primary Care Provider. If you decide to change your Primary Care Provider, please remember to have your medical records transferred to your new Primary Care Provider.

3.2.5 Office Visits

Primary Care Providers

We recommend you see your Primary Care Provider for all routine care and call your Primary Care Provider first for urgent or specialty care. If you need medical care when your Primary Care Provider is not available, the physician/provider on call may treat you and/or recommend that you see another provider for treatment.

Specialists

Your Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a specialist for treatment.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who is an In-Network Provider with Providence Health Plan.

If you decide to see a specialist on your own, we recommend you let your Primary Care Provider know about your decision. Your Primary Care Provider will then be able to coordinate your care and share important medical information with your specialist. In addition, we recommend you let your specialist know the name and contact information of your Primary Care Provider.

Whenever you visit a specialist:

- Bring your Providence Health Plan Member ID Card.
- Understand that in most cases, your out-of-pocket costs will be a percent of the charges for services. Your provider's office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and will bill or credit you the balance later. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Chiropractic Care Providers

This Plan includes coverage for specified chiropractic services. See section 4.15 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

As a Member of this Plan, you may choose to receive Covered Services from Out-of-Network Qualified Practitioners and facilities using your Out-of-Plan benefit.

Benefits for Covered Services by an Out-of-Network Provider will be provided as shown in the Benefit Summary. See section 3.5 Prior Authorization requirements.

Generally, when you receive Services from Out-of-Network Providers, your Copayments and Coinsurance will be higher than when you see In-Network Providers.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If an Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an Out-of-Network Provider, those Services are still subject to the terms of this Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

If the provider you choose is Out-of-Network, it is important for you to understand that Providence Health Plan has not assessed the provider's credentials or quality; nor has Providence Health Plan reviewed and verified the Out-of-Network Provider's qualifications and history for information such as: relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Additionally, the Out-of-Network Provider will not have been assessed by Providence Health Plan to verify that the provider meets certain criteria relating to professional competence and conduct and as such is not guaranteed to follow your benefit plan, rules, regulations, or guidelines with regard to standards of care nor standards of documentation and billing.

Some Services are only covered under your In-Plan benefit:

- Web-direct Visits (see section 4.3.2).
- E-mail Visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Retail health Clinic Visits (see section 4.3.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" under Out-of-Plan.

Payment for Out-of-Network Physician/Provider Services (UCR)

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Plan benefits as shown in the following example (amounts shown are only estimates of what may apply).

	Provider's Status	
Item	In-Network	Out-of-Network
Provider's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount that the provider may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.

Payment for Covered Services Provided Before Disposition of Criminal Charges

If you are in the custody of an Oregon state or local corrections agency pending the disposition of criminal charges brought by an Oregon county, we will reimburse the custodial county for the costs of Covered Services or supplies rendered before the disposition of charges, in an amount that is no less than 115 percent of the Medicare rate for the service or supply, except for renal dialysis which will be reimbursed in accordance with the terms of the Plan for Out-of-Plan dialysis providers.

The following Services and Supplies are excluded from coverage under this section:

- Diagnostic tests or health evaluations required by the corrections agency, as a matter of course, for all individuals who are in the custody of the county pending the disposition of charges;
- Hospital and ambulatory surgical center services, except as rendered by an In-Plan provider.

3.4 NOTICE OF PROVIDER TERMINATION

When an In-Network Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within 10 days of the termination date or of our knowledge of the termination date.

3.5 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from In-Network Providers:
When Services are received from an In-Network Provider, the In-Network Provider is responsible for obtaining Prior Authorization.

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.6.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.2.
- All Applied Behavior Analysis, as provided in section 4.10.3.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.

- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.
- Certain medications, including certain immunizations, received in your Provider's office as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

Providence Health Plan will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call Customer Service at the number listed on your Member ID Card.

If an Emergency Medical Condition exists which prevents you from obtaining Prior Authorization, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

Prior Authorization Requests for Out-of-Plan Services:
The Member or the Out-of-Network Provider must call us at 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:

- The Member's name and date of birth.
- The Member's Providence Health Plan Member number and Group number (these are listed on your Member ID card).
- The Provider's name, address and telephone number.
- The name of the Hospital or treatment facility.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

Failure to Obtain Prior Authorization:
If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty**, not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary.

3.6 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.7 MEDICAL COST MANAGEMENT

Coverage under this Plan is subject to the medical cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

The Plan reserves the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by Providence Health Plan. When more than one medically appropriate alternative is available, Providence Health Plan will approve the least costly alternative.

In accordance with Providence Health Plan's medical cost management protocols and criteria specified in this paragraph, Providence Health Plan may approve substitutions for Covered Services under this Plan.

A Substituted Services must:

1. Be Medically Necessary;
2. Have your knowledge and agreement while receiving the Service;
3. Be prescribed and approved by your Qualified Practitioner; and
4. Offer a medically therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

The Plan's coverage of a Substituted Service for any Member does not obligate the Plan to:

- Cover a Substituted Service for any other Member;
- Continue to cover a Substituted Service beyond the term of the agreement between the Plan and the Member; or
- Cover any Substituted Service for the Member, other than as specified in the agreement between the Plan and the member.

Substituted Services that satisfy the requirements of this section are Covered Services for all purposes under this Plan.

A Substituted Service may be disallowed at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.

3.7.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

Providence Health Plan has developed standards to guide the evaluation process and to ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage:

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

A committee of medical directors with physician specialist advisors evaluates all new technology and determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services that provide independent analysis of a new technology.

Expedited Review

Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 7.

3.8 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in

section 15. Services that do not meet Medically Necessary criteria will not be covered.

- ***Example:*** *Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.*
- ***Example:*** *You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor's office. The Plan would not pay for that visit.*
- ***Example:*** *You stay an extra day in the hospital only because the relative who will help you during recovery cannot pick you up until the next morning. We may not pay for the extra day.*

Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.9 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial. If your Approved Clinical Trial is available through both Network and Out-of-Network providers, the Plan will require you to participate through an In-Network Provider.

Covered Services include the routine patient costs for items and services received in connection with the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services under the Plan.

The following costs are excluded:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for services unrelated to a clinical trial to the extent that the services are otherwise Covered Services under the Plan.

3.10 HOW BENEFITS ARE APPLIED

Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:

1. The Deductible;
2. The Copayment or Coinsurance amount; and
3. The benefit limits and/or maximums.

3.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Your Plan has a Deductible and an Out-of-Pocket Maximum, as stated in your Benefit Summary.

3.11.1 Understanding Deductibles

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year when receiving most Covered Services before benefits are provided by us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

Certain Covered Services, such as most In-Plan preventive care, are covered without a Deductible. Please see your Benefit Summary for information about these Services.

***Common In-Plan and Out-of-Plan Deductible*:** Your Plan has a **Common Deductible**, as listed in your Benefit Summary. **A Common Deductible applies to both In-Plan and Out-of-Plan benefits**. The Common Deductible can be met by using In-Plan or Out-of-Plan benefits, or a combination of both.

***Individual Deductible*:** An Individual Deductible is the amount shown in the Benefit Summary that must be paid by a Member before the Plan provides benefits for Covered Services for that Member.

***Family Deductible*:** The Family Deductible is the amount shown in the Benefit Summary that applies when three or more Family Members are enrolled in this Plan, and is the maximum Deductible that enrolled Family Members must pay. All amounts paid by Family Members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled Family Members.

Note: No Member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services for that Member.

***Your Costs that Do Not Apply to Deductibles*: The following out-of-pocket costs do not apply towards Your Individual and Family Deductibles**:

- Services not covered by this Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

***Deductible Carry Over*:** Applicable charges for Covered Services used to meet any portion of the Deductible during the fourth quarter of a Calendar Year will be applied toward the next year's Deductible.

3.11.2 Understanding Out-of-Pocket Maximums

Out-of-Pocket Maximums are the total amount you will pay out-of-pocket in any Calendar Year, in addition to your deductible, for Covered Services received under this Plan. See your Benefit Summary.

***Common In-Plan and Out-of-Plan Out-of-Pocket Maximums*:** Your Plan has a Common In-Plan and Out-of-Plan Out-of-Pocket Maximum, as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Plan and Out-of-Plan benefits.

***Individual Out-of-Pocket Maximum*:** Individual Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

***Family Out-of-Pocket Maximum*:** Family Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family of three or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment and Coinsurance expenses of enrolled Family Members meet the family Out-of-Pocket Maximum, all remaining individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Note: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

***Your Costs that Do Not Apply to Out-of-Pocket Maximums*:** The following out-of-pocket costs do not apply toward your Individual and Family Out-of-Pocket Maximums:

- Services not covered by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

IMPORTANT NOTE: Some Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services, as shown in the Benefit Summary, remains in effect throughout the Calendar Year.

4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

Benefits are provided for preventive care and for the treatment of illness or injury when such treatment is Medically Necessary and provided by a Qualified Practitioner as described in this section and shown in the Benefit Summary.

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section4.2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, http://www.hrsa.gov/womens-guidelines.

Note: Additional Plan provisions apply to some Services (e.g., routine physical examinations and well-baby care must be received from an In-Network Primary Care Provider, see section 4.1.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered only when received from an In-Network Primary Care Provider. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

Infants up to 30 months:	Up to 12 well-baby visits.
Children and Adolescents:	
3 years through 21 years:	One exam every year.
Adults:	
22 years through 29 years:	One exam every five years.
30 years through 49 years:	One exam every two years.
50 years and older:	One exam every year.

If, at the time of your routine physical examination or well-child care, you need paperwork completed for a third party, such as school, camp, team sports, etc., your provider may charge you a fee to complete the paperwork. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, except as specified in section 4.12.11.

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.

4.1.3 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by a Qualified Practitioner for men designated high risk.

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members age 50 and older include:

- One fecal occult blood test per year, plus one sigmoidoscopy every five years; or
- One colonoscopy every 10 years; or
- One double contrast barium enema every five years.

Screening examinations and lab tests for Members designated high risk are covered as recommended by the Qualified Practitioner.

For Members age 50 and older:

- In-Plan: All Services for colorectal cancer screenings and exams are covered in full.
- Out-of-Plan: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit.

For Members under age 50:

- In-Plan and Out-of-Plan: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.

4.1.5 Preventive Services for Members with Diabetes

Preventive Services benefits for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- A dilated retinal exam by a qualified eye care specialist every Calendar Year;
- A glycosylated hemoglobin (HbA1c) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth (dental visits are not covered); foot inspection; and influenza vaccine by a Qualified Practitioner every Calendar Year; and
- A pneumococcal vaccine every five years.

4.1.6 Diabetes Self-Management Education Program

Benefits are paid in-full for diabetes self-management education programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes as prescribed by a Qualified Practitioner. “Diabetes self-management program” means one program of assessment and training after diagnosis as well as assessment and training upon a material change of condition, medication or treatment. All services must be received from licensed providers and facilities, practicing within scope of license.

4.1.7 Nutritional Counseling

A maximum of two visits per Calendar Year are covered for nutritional counseling when Medically Necessary, as determined by the Qualified Practitioner. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services

Coverage is provided for participation in a Providence Health Plan-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. “Tobacco use cessation program” includes educational and medical treatment components such as, but not limited to, counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of Providence Health Plan-approved programs is available online at www.ProvidenceHealthPlan.com (select “search” and enter “tobacco cessation”) or by calling Customer Service at 503-574-7500 or 800-878-4445.

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

4.2.1 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and Pap examinations once every Calendar Year or more frequently for women who are designated high risk. Family planning Services are separate (see section 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider.

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Lactation Counseling Services must be received from licensed providers. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through In-Network Medical Equipment Providers. Out-of-Plan, coverage is subject to your Durable Medical Equipment (DME) benefits.

4.2.4 Family Planning Services

Benefits include counseling, exams, and services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Participating Pharmacy.

All Covered Services must be received from Qualified Practitioners and Facilities or purchased from Participating Pharmacies.

- In-Plan: Services are covered in full.
- Out-of-Plan: Services are covered subject to the provisions of the applicable In-Plan or Out-of-Plan benefit, e.g. IUDs and diaphragms are covered under your medical supply benefit.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.10.

4.3 PROVIDER SERVICES

4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Some services provided by your Qualified Practitioner during your visit may result in additional Member financial responsibility.

For example – You see your Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific services, such as allergy shots, maternity care, and diagnostic services. See your Benefit Summary for details.

If you are unable to keep a scheduled office appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Providence Health Plan will not cover this expense.

4.3.2 Virtual Visits

The Plan provides coverage for Virtual Visits using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and may be received from authorized In-Network or Out-of-Network Providers. Not all Providers are contracted with us to provide Phone and Video Visits. Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers who may be approved for E-mail Visits. In-Network Providers who are authorized to provide E-mail Visits have agreed to use Internet security technology approved by us to protect your information from unauthorized access or release. To be eligible for the E-mail Visit benefit, you must have had at least one prior office visit with your In-Network Provider within the last 12 months.

Covered E-mail Visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by the Plan;
- Communications by the In-Network Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of e-mail communications that do not qualify as E-mail Visits include, but are not limited to:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
- All communications in connection with Mental Health or Substance Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service:

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site.

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

4.3.7 Immediate Care

Immediate Care is an extension of your Primary Care Provider's office, and provides additional access to treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Immediate Care Provider.

4.3.8 Retail Health Clinic

Coverage is provided as shown in the Benefit Summary for Covered Services obtained at Retail Health Clinics. Retail Health Clinics can provide diagnosis and treatment services for uncomplicated minor illnesses and injuries, like sore throats, ear aches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

4.4 DIAGNOSTIC SERVICES

Coverage is provided as shown in your Benefit Summary for Diagnostic Services.

4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

4.4.2 Sleep Study Services

Benefits include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

Benefits for Emergency Services and Urgent Care Services are provided as described below and shown in your Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

4.5.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Medically necessary detoxification
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Unexpected premature childbirth

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:

"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child.

"Emergency Services" means, with respect to an Emergency Medical Condition:

- An Emergency Medical Screening Exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"Emergency Medical Screening Exams" include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card.

Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care.

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits.

Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition

becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 3.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

4.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary emergency care or to a facility specified by Providence Health Plan. Air ambulance transportation is only covered for a life-threatening medical emergency, or when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time. Ambulance transportation solely for personal comfort or convenience is not covered.

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions resulting from an injury to or illness of the eye(s). Members may receive Services directly from an optometrist or ophthalmologist or from a Hospital emergency room.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their office is not Urgent Care.

Whenever you need urgent care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be

treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Qualified Provider.

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

When you are admitted to an Out-of-Network Hospital from an Urgent Care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

Not all Out-of-Network facilities will file a claim on a Member's behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services.

Covered Services do NOT include care received that consists primarily of:

- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases, the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

- Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

In-Plan Benefit: When your In-Network Provider and Providence Health Plan determine you

need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital.

Out-of-Plan Benefit: You are responsible for making sure inpatient hospitalization services are Prior Authorized by Providence Health Plan before receiving this care from an Out-of-Network Hospital.

Only Medically Necessary hospital services are covered. Covered inpatient Services received in a Hospital are:

- Acute (inpatient) care;
- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care, and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by Providence Health Plan and prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary.

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitation benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.2 for coverage of Outpatient Rehabilitative Services.)

4.6.4 Inpatient Habilitative Care

Coverage is provided for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day

treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24 - 48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy, and Multidisciplinary Pain Management Programs

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5.

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.) All Services are subject to review for Medical Necessity.

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as stated in the Benefit Summary, for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Deductible, Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits, and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

<u>Covered Services include:</u>

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care*.
- Newborn nurse home visits**.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit.

**Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services.

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

The services of a lay, unlicensed direct entry, certified professional, or any other unlicensed midwife are not covered.

Length of maternity hospital stay: Your services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery, and a minimum of 96 hours for a Caesarean delivery. You will not be discharged from the hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

Maternity support services: Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

Diabetes coverage during pregnancy: During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Plan.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME)

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) are provided as shown in the Benefit Summary when required for the standard treatment of illness of injury. Providence Health Plan may authorize the purchase of an item if they determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by a Qualified Practitioner.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or

more efficient model are not covered unless Medically Necessary. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.

4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

Benefits are provided as shown in the Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.

6. Other Medically Necessary appliances, including Hearing Aids and Hearing Assisted Technology (HAT) as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck; or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 4.9.2).

4.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by Providence Health Plan.

Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.5.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or

psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:
- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program;
- Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

An approved ABA treatment plan is subject to review by us, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

4.10.3 Substance Abuse Services

Benefits are provided for Substance Abuse Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan.

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.5.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified

within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.11 HOME HEALTH AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and are described below. The Plan will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Plan.

Any visit by a person providing Services under a home health care plan, or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency. If you were hospitalized immediately prior to the commencement of home health care, the home health care plan must be initially approved by the Qualified Practitioner who was the primary provider of Services during the hospitalization.

If the above criteria are not met, NO benefits will be provided under this Plan for home health care.

Rehabilitation services provided under an authorized home health care plan will be covered as home health care Services.

Home health care benefits do NOT include:

1. Charges for mileage or travel time to and from your home;
2. Wage or shift differentials for Home Health Providers;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services

include the following:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.5.

All Direct-to-Consumer genetic tests are considered investigational and are not covered.

4.12.2 Inborn Errors of Metabolism

The Plan will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, spinal fluid, or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.

4.12.5 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

- Reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;

- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in 4.12.7.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services from an In-Network Provider as shown in the Benefit Summary. Covered Services include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic X-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 4.9.2(Medical Appliances). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and
6. Surgical Services.

TMJ Services are covered as shown in your Benefit Summary; limits may apply.

Out-of-Plan benefits do not apply to TMJ Services.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered under your Prescription Drug benefit when received from a Participating retail or specialty Pharmacy as shown in the Benefit Summary (See section 4.14).

4.12.9 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.10 Elective Sterilization

Coverage is provided, as stated below, for voluntary sterilization (tubal ligation and vasectomy).

All Covered Services must be received from Qualified Providers and Facilities.

- In-Plan: Services are covered in full.
- Out-of-Plan: Services are covered subject to the provisions of the applicable Out-of-Plan benefit, e.g., your Inpatient or Outpatient Surgery benefit.

Please note: Providence Health Plan is a Catholic-sponsored health plan, and, as a matter of conscience, Providence Health & Services facilities do not offer these Services. Services are available at other In-Network Facilities.

4.12.11 Hearing Loss Services

Definitions:

Cochlear Implant

Cochlear Implant means a device that can be surgically implanted under the skin in the bony area behind the ear (the cochlea) to stimulate hearing.

Hearing Aid

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries or accessory for the instrument or device, except cords.

Covered Services:

The following hearing loss services are covered under this Plan as described below. Benefits for such services are provided at the applicable benefit level for that particular type of service, as listed in your Benefit Summary.

All Covered Services must be Medically Necessary and appropriate, and prescribed, fitted, and dispensed by a licensed audiologist, hearing aid/instrument specialist, or other Qualified Practitioner.

Cochlear implants:

Cochlear implants for one or both ears, including programming, reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.

Hearing aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year.

Diagnostic & Treatment Services

Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit.

Hearing Assistance Technology:

- Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.

Limits to Hearing Loss Services

Coverage for hearing loss services are provided in accordance with state and federal law.

4.12.12 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person's body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with Providence Health Plan (the Out-of-Plan benefit does NOT apply to transplant Services);
3. Involve one or more of the following organs or tissues:
    - Heart
    - Lung
    - Liver
    - Kidney
    - Pancreas
    - Small bowel
    - Autologous hematopoietic stem cell/bone marrow
    - Allogeneic hematopoietic stem cell/bone marrow; and
4. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel expenses are not covered for donors.)

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other Health Benefit Plan or government funding program. Covered Services for donors include:

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Member/recipient is responsible for the Coinsurance or Copayment amounts for pre-transplant services and post-transplant services at the applicable Inpatient Hospital Services and Outpatient Facility Services benefit.

The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition, and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.

The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for those Services, as shown in the Benefit Summary, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member's Out-of-Pocket Maximum.

4.13.5 Transplant Prior Authorization

(See also section 3.5.)

To qualify for coverage under this Plan, all transplant-related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant;
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by Providence Health Plan;
- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and

- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions.

Prescription Drug Definition

The following are considered "Prescription Drugs":

1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription";
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal or state legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Evidence Review as effective for the treatment of a particular indication.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

You have access to Providence Health Plan's nationwide broad pharmacy network as published in our pharmacy directory.

Providence Health Plan Participating Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at www.ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.
- Participating Pharmacies may not charge you more than your Copayment or Coinsurance. Please contact Customer Service if you are asked to pay more or if you,

or the pharmacy, have questions about your Prescription Drug Benefit or need assistance processing your prescription.

- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drugs at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at www.ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies.)
- Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network Pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. Reimbursement is subject to your Plan's limitations and exclusions. You are responsible for any amounts above our contracted rates.

International prescription drug claims will only be covered when prescribed for emergent conditions and will be subject to your medical Emergency Services benefit and any applicable Plan limitations and exclusions.

4.14.3 Prescription Drug Formulary

The Formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives.

The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices to treat most medical conditions.

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See Section 6.1 under Claims Involving Prior Authorization and Formulary Exception.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the Formulary for your Plan, visit https://healthplans.providence.org/members/pharmacy-resources/.

4.14.4 Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.

If you request a brand-name drug, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Participating Pharmacies; and
6. Opioids up to 7 days initial dispensing.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs are those you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.
3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If Providence Health Plan removes a pharmacy from its network, we will notify you of this change at least 30 days in advance. Notification may be done via the online directory or letter depending on the circumstance.

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.

3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances, specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria, and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.
7. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
8. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug Exclusions

In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows:

1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 10 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Drugs prescribed by naturopathic physicians (N.D.);
9. Over-the-counter (OTC) drugs or vitamins, that may be purchased without a provider's written prescription, except as required by federal or Oregon state law;
10. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
11. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions or as required by federal or Oregon state law;

12. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
13. Replacement of lost or stolen medication;
14. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
15. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
16. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs used for weight loss or for cosmetic purposes;
20. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
21. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
22. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.

4.14.9 Prescription Drug Disclaimer

Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

4.15 CHIROPRACTIC CARE BENEFIT

The Chiropractic Care Supplemental Benefit provides coverage for Services received from Chiropractic Care Providers provided that the Services are Medically Necessary and are within the scope of practice of the provider involved in your care.

All Chiropractic Care benefits are subject to any conditions and benefit limits stated in your Chiropractic Care Benefit Summary and in this section.

All chiropractors must be licensed in the state in which they practice and must practice within the scope of their license.

4.15.1 Chiropractic Care Providers

All Members must receive Covered Services from our nationwide network of Network chiropractors. To find a chiropractic care In-Network Provider in your area, visit our website at ProvidenceHealthPlan.com/findaprovider or call Customer Service.

You do not need a physician's referral to see a chiropractor.

In rare circumstances, our national network may not include a Network chiropractor in your area. If this happens, please contact Customer Service before making an appointment. If

Customer Service is unable to locate an In-Network Provider within a reasonable distance, authorization for use of an Out-of-Network Provider will be provided.

In some cases, you will need to pay the Out-of-Network Provider directly for the care you receive, and then submit your itemized billing statement to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

Reimbursement for services from Out-of-Network Providers is subject to Plan approval. The Plan will reimburse you the cost of your services at a Usual, Customary and Reasonable rate, less your applicable Copayment or Coinsurance. You will be responsible for all amounts over the UCR.

4.15.2 Chiropractic Care Services

Covered Services from chiropractors:

- Office visits.
- Chiropractic manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are Medically Necessary for the treatment of neuromusculoskeletal disorders.
- Related diagnostic X-rays and laboratory Services.

The following services are NOT covered from chiropractors:

- Preventive care services.
- Services, exams and/or treatments for conditions other than neuromusculoskeletal disorders.
- All chiropractic appliances or Durable Medical Equipment.
- Adjunctive physiotherapy not associated with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor's office.
- Venipuncture.
- Services received from a chiropractor that are not listed as a Covered Service.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Education programs, self-care or self-help programs or any self-help physical exercise training or any related diagnostic testing.
- Transportation costs including local ambulance charges.
- Massage therapy.
- Thermography.
- Therapeutic modalities and procedures that are considered by us or our authorizing agent to be invasive.
- Emergency care and Urgent/Immediate care services.
- Any service or supply that is not permitted by state law with respect to the chiropractor's scope of practice.

- Services in excess of the benefit limits listed in the Chiropractic Care Supplemental Benefit Summary.
- Services received from Out-of-Network Providers, except as discussed in this section.

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, the following are specifically excluded from coverage under this Plan.

General Exclusions:

The Plan does not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition).

The Plan does not cover:

- Charges that are in excess of the Usual, Customary, and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient except as covered in section 4.3.2.
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.6 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;

- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;
- Recreation services, therapeutic foster care, and wraparound services; emergency aid for household items and expenses; services to improve economic stability, and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of licensed acupuncturists, a physician performing acupuncture Services, naturopathic physicians, chiropractic physicians and licensed massage therapists, except as provided in section 4.15;
- Services of homeopaths; faith healers; or lay, unlicensed direct entry and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;
    - All services related to artificial insemination, including charges for semen harvesting and storage;
    - Diagnostic testing and associated office visits to determine the cause of infertility;

- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
    - Physical examination;
    - Related laboratory testing;
    - Instruction;
    - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
    - Related supplies and prescriptions.

  For the purpose of this exclusion:
  - Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
  - Artificial reproduction means the creation of new life other than by the natural means.
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2; and
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first;
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.11.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth; dental implants), except as approved by us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

6. CLAIMS ADMINISTRATION

This section explains how the Plan treats various matters having to do with administering your benefits and/or claims, including situations that may arise in which your health care expenses are the responsibility of a source other than this Plan.

6.1 CLAIMS PAYMENT

The Plan's payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly and pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to the Plan of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber's estate, unless payment to other parties is authorized in writing by you.

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after your claim has been processed. An EOB is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If your claim is denied under the Plan, Providence Health Plan will send an EOB to you with an explanation of the denial within 30 days after your claim is received. If additional time is needed to process your claim for reasons beyond Providence Health Plan's control, you will be sent a notice of delay explaining those reasons within 30 days after your claim if received. The processing will then be completed and you will be sent an EOB within 45 days after your claim is received. If additional information is needed from you to complete the processing of your claim, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you is received, Providence Health Plan will complete the processing of the claim within 30 days.

Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)

- **For Prior Authorization of services that do not involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete their review and provide written notice of its decision to the Member and the provider of their decision. If the information is not received within 15 days, the request will be denied.

- **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.
- **For Formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.

Claims Involving Concurrent Care Decisions. If an ongoing course of treatment for you has been approved under the Plan and it is determined through Concurrent Review procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request a reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. You will then be notified of Providence Health Plan's reconsideration decision within 24 hours after your request is received.

6.1.1 Timely Submission of Claims

The Plan will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if Providence Health Plan receives documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon insurance Division's administrative rule setting standards for prompt payment. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

6.1.2 Right of Recovery

The Plan has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from the Plan under any contract.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB

provision to coordinate other benefits.

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and may reduce the benefits payable so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If the Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If the Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If the Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because the Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

6.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
C. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
        a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
            i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or

ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
      - The Plan covering the Custodial parent, first;
      - The Plan covering the spouse of the Custodial parent, second;
      - The Plan covering the non-custodial parent, third; and then
      - The Plan covering the Dependent spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:
   i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.
   ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a

Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than would have paid had This Plan been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, benefits may be reduced so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give us any facts Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.2.6 Right of Recovery

If the amount of the payments made by This Plan is more than what should have paid under this COB section, This Plan may recover the excess from one or more of the persons This Plan paid or for whom This Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions.

In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed to be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B.

When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare.

Counting individuals for the Employer size:

- Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.
- Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member's policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for the Plan to deny any claims for benefits arising from the condition or to terminate the Member's coverage under this Plan as specified in section 9.4. In addition, you or the Member must execute and deliver to the Plan and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and the Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the Plan or the Member. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member's heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which the Member or the Member's heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, the Plan will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Plan.

If the Plan makes claim payments on any Member's behalf for any condition for which a third party is responsible, the Plan is entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery.

"Subrogation" means that the Plan may collect directly from the third party to the extent the Plan has paid for third-party liabilities. Because the Plan has paid for the Member's injuries, the Plan, rather than the Member, is entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify the Plan in writing of any terms or conditions offered in settlement and must notify the third party of the Plan's interest in the settlement established by this provision.

To the maximum extent permitted by law, the Plan is subrogated to the Member's rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member's name, and has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

To accomplish this process, the Plan needs detailed information from you or from the Member. A questionnaire will be sent to the Member for this information. It should be completed and returned to Providence Health Plan as soon as possible to minimize any claim review delay. If you or the Member has any questions or concerns regarding the questionnaire, please contact Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason the Plan is not paid directly by the third party, the Plan is entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and the Plan may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by the Plan, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, the Plan is entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. The Plan is entitled to recover up to the full value of the benefits provided by the Plan for the condition, calculated using the Plan's UCR charges for such Services, less the Plan's pro-rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. The Plan is entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Plan, the Member acknowledges the Plan's first priority to this repayment and assigns to us any benefits the Member may have from other sources. The Member must cooperate fully with the Plan and Providence Health Plan in recovering amounts paid by the Plan. If any Member seeks damages against the third party for the condition and retains an attorney or other agent for representation in the matter, that Member agrees to require the Member's attorney or agent to reimburse the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan directly from any settlement or recovery. The Plan may withhold benefits for the Member's condition until a signed copy of this agreement is delivered to the Plan. The agreement must remain in effect and the Plan may withhold payment of benefits if, at any time, the Member's confirmation of the obligations under this section should be revoked. While this document is not necessary for the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that the Plan would otherwise be required to pay under this Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, the Plan is not required to provide coverage for continuing treatment until the Member proves to the Plan's satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. The Plan will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using the Plan's UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. The Plan is entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate you for your medical expenses, regardless of any allocation of proceeds in any settlement document that the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled Family Member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 6.3.2 and 6.3.3 above are modified as provided below.

Before the Plan will be entitled to recover from under a settlement or recovery, you or your enrolled Family Member must first have received full compensation for your injuries. The Plan's entitlement to recover will be payable only from the total amount of the recovery in excess of the amount that fully compensates for the injured person's injuries.

The Plan will not deny or refuse to provide benefits otherwise available to you or your enrolled Family Member because of the possibility that a third party recovery may potentially be available against the person who caused the accident or out of motor vehicle liability or underinsurance coverage.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Your Customer Service representative is available to provide information and assistance. You may call or meet with Providence Health Plan at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;

- Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an internal review. You may request review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or grievance with Providence Health Plan. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or Appeal and Providence Health Plan will consider that information in the review process.
- You can be represented by anyone of your choice at all levels of Appeal.

Request for Claim/Appeal File and Additional Information:

- You can, upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to our decision at any time before, during, or after the appeal process. This includes the specific internal rule, guidelines, protocol, or other similar criterion relied upon to make the Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable.
- You also have the right to request free of charge, at any time, the diagnostic and treatment codes and their meanings that are the subject of your claim or appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.

If you receive the services that were denied in the Adverse Benefit Determination, and if the Adverse Benefit Determination is upheld by internal or external review, you will be financially responsible for any benefits paid by the Plan for such services.

To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. Providence Health Plan will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines as noted below.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling Customer Service at 503-574-7500 or 800-878-4445 outside of the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. Providence Health Plan will let you know by phone and letter if your case qualifies for an expedited review. If it does, you will be notified of the decision within 72 hours of receiving your request.

Grievances and Appeals Involving Concurrent Care Decisions: If Providence Health Plan has approved an ongoing course of treatment for you and determines through medical management procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal is of an Adverse Benefit Determination that involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary, you may request an external review by an IRO. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary.**

The Plan pays all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal or requests for External Review to 503-574-8757 or 800-396-4778, or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

If you decline coverage or fail to enroll when you first become eligible, the next earliest time you may enroll is the next occurring Open Enrollment Period.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

Clackamas County will provide an Open Enrollment Period each Plan Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Plan Year for which they enroll.

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine

the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

In instances where an Eligible Family Dependent of a Subscriber qualifies for a "special enrollment period," the Subscriber and the Eligible Family Dependent may:

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) because of other health coverage and you lose that other coverage, the Plan will provide a "special enrollment period" for you and/or your Eligible Family Dependent if:

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and
b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and
c) Such coverage:
    - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
    - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
        1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
        2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized

health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or

3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

Effective Date: Coverage under this Plan will take effect on the first day after the other coverage ended.

8.3.2 New Dependents

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.

The "special enrollment period" shall be a period of 60 days and begins on the later of:

- the date Dependent coverage is made available under this Plan; or
- the date of the marriage, birth, or adoption or placement for adoption.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

If you or your Eligible Family Dependent were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children's Health Insurance Program (CHIP)-sponsored arrangement, the Plan will provide a "special enrollment period" for you and your Family Member(s) if you request enrollment

within 60 days after the date of entitlement.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

For the Subscriber, a leave of absence granted under the federal Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

Termination of Member coverage under this Plan will occur on the earliest of the following dates:

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County of any changes in eligibility including the lack of eligibility of a Family Member. Coverage will not continue beyond the last date of eligibility, regardless of the lack of notice to Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered Dependents the benefits paid as a result of such wrongful activity. Providence Health Plan will provide all affected Plan participants with 30 days' notice before rescinding coverage.

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated because you have engaged in fraudulent, dishonest or threatening behavior, such as:

1. You have filed a false claim with the Plan;
2. You willfully fail to provide information or documentation required to be provided under this Plan or knowingly provide incorrect or incomplete information;
3. You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County reserves the right at any time to terminate or amend in whole or part any of the provisions of the Plan or any of the benefits provided under the Plan. Any such termination or amendment may take effect retroactively or otherwise. In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction and no payments scheduled to be made on or after such effective date will result in any liability to the Plan or Clackamas County.

10. CONTINUATION OF GROUP MEDICAL BENEFITS

If you become ineligible for coverage under this Plan you may, under certain circumstances, continue group coverage. There are specific requirements, time frames and conditions that must be followed in order to be eligible for continuation of group coverage and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that applies to most Employers with 20 or more employees. Some Employers, such as church groups and state agencies, may be exempt from COBRA. The law requires that Employers subject to COBRA offer Employees and/or their Dependents continuation of medical and dental coverage in certain instances where there is a loss of group coverage.

10.1.1 Subscriber's Continuation Coverage

A Subscriber who is covered under this Plan may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

A Spouse or Domestic Partner who is covered under this Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the Subscriber and the Spouse;
- Termination of the domestic partnership; or
- The Subscriber becomes covered under Medicare.

10.1.3 Dependent's Continuation Coverage

A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours;
- The Subscriber's divorce or legal separation;
- Termination of the domestic partnership;
- The Subscriber becomes covered under Medicare; or
- The child ceases to qualify as an Eligible Family Member under this Plan.

A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 Notice Requirements

A Family Member's coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs or a child loses Dependent status under this Plan. **Under COBRA, you or your Family Member has the responsibility to notify Clackamas County if one of these events occurs.** Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When Clackamas County receives notification of one of the above "qualifying" events, you will be notified that you or your Family Member, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, your right to elect continuation coverage under this Plan will be lost.

10.1.5 Type of COBRA Continuation Coverage

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

10.1.6 COBRA Election Rights

A Subscriber or their Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

10.1.7 COBRA Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay the premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.

10.1.8 Length of COBRA Continuation Coverage

18-Month Continuation Period

When coverage ends due to a Subscriber's termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the Subscriber and all covered Family Members will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

29-Month Continuation Period

If a qualified beneficiary is disabled, continuation coverage for that qualified beneficiary and their covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides Clackamas County with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days.

36-Month Continuation Period

If a Spouse, Domestic Partner or Dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The Subscriber's death;
- The Subscriber's eligibility for Medicare;
- Divorce or legal separation;
- Termination of the domestic partnership; or
- A child becomes ineligible for Dependent coverage.

10.1.9 Extension of Continuation Period

If a second qualifying event occurs during the initial 18- or 29-month continuation period (for example, the death of the employee, divorce, or child loses status as an Eligible Family Member under the Plan), coverage for a qualified beneficiary may be extended up to 36 months. However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a Spouse or Dependent child has continuation coverage due to the employee's termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee's Medicare entitlement date.

10.1.10 Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the Pension Benefit Guaranty Corporation (PBGC), to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of sixty-five percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax

Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY caller may call toll-free at 866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

10.1.11 When COBRA Continuation Coverage Ends

COBRA Continuation coverage will end automatically for you and your Family Members when any of the following events occurs:

- Clackamas County no longer provides health coverage to any employees;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary (employee, spouse or dependent child) later becomes covered under another health plan;
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. Providence Health Plan wants you to have a positive experience, and are ready to help in any way.

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and In-Network Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS)

The following information applies to Members (participants) who are covered by a plan that is not subject to ERISA.

As a participant in Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, provided you request it in writing and reasonably describe the information.
    - You may obtain copies, subject to paying a reasonable copying charge.
    - You are entitled to know to whom we may have disclosed any such information.
    - You are entitled to correct any errors in the information.

2. Continue group health coverage
    - Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.1.
3. Enforce your rights

    If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

    As more fully described in section 7, the Plan offers a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (IRO) decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2.

    Member's sole right of Appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between the Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A child of an Eligible Employee will be enrolled in the Plan as required by a qualified medical child support order. The procedures and rules regarding this enrollment are described in this section.

12.1 DEFINITIONS

For purposes of this section, the following definitions shall apply:

"Alternate Recipient" means any child of an employee who is recognized under an Order as having a right to enrollment under the Plan with respect to such employee.

An "Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (or through an administrative process established under a state law which has the effect of a court order) which:

- Provides for child support with respect to a child of an employee under the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or
- Enforces a state law relating to medical child support with respect to the Plan.

A "Qualified Medical Child Support Order" or "QMCSO" means an Order:

- Which creates or recognizes the existence of an Alternate Recipient's right to receive, or assigns to an Alternate Recipient the right to receive, benefits for which an employee or beneficiary is eligible under the Plan; and
- With respect to which Clackamas County has determined satisfies the QMSCO standards set forth below.

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section.

"Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County will promptly notify the employee and each Alternate Recipient identified in such Order of the receipt of such Order, and will further furnish them each with a copy of these Procedures. If the Order or any accompanying correspondence identifies a Designated Representative, then copies of the acknowledgment of receipt notice and these Procedures will also then be provided to such Designated Representative.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County will determine whether the Order satisfies the QMCSO standards described below so as to constitute a QMCSO, and shall thereupon notify the employee, each Alternate Recipient, and any Designated Representative of such determination.

An Order will not be deemed to be a QMCSO unless the Order:

(a) Clearly specifies:
    1. The name and last known mailing address (if any) of the employee and of each Alternate Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);
    2. Either a reasonable description of the type of coverage to be provided under the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
    3. The period to which the Order applies.

(b) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

If an Order contains inconsistencies or ambiguities that might pose a risk of future controversy or liability to the Plan, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to Clackamas County will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been voluntary enrolled in the Plan by the employee as a dependent of such employee, including in regard to the payment by the employee for dependent coverage under the Plan. The amount of any required contributions to be made by the Employee for coverage under the Plan will be determined on the basis of the Alternate Recipient being treated as the employee's covered dependent. Any additional required contribution attributable to the coverage of the Alternate Recipient will not be separately charged. Rather, the full amount of the required contribution shall be paid by the employee in accordance with the payroll deduction or other procedures of the Plan as pertaining to the employee.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the employee. Rather, such reimbursement will be paid either to the Alternate Recipient, or to the custodial parent or legal guardian of such Alternate Recipient. However, if the name and address of a State or agency official has been substituted in the Order for that of the Alternate Recipient, then the reimbursement will be paid to such named official.

12.7 STATUS OF ALTERNATE RECIPIENT

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the

Employee under the Plan to which the Order pertains.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County receives an appropriately completed National Medical Support Notice (a "National Notice") issued pursuant to the Child Support Performance and Incentive Act of 1998 in regard to an employee who is a non-custodial parent of a child, and if the National Notice is determined by Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, shall within forty (40) business days after the date of the National Notice notify the State agency issuing the National Notice of the following:

(a) Whether coverage of the child at issue is available under the terms of the Plan, and if so, as to whether such child is covered under the Plan; and
(b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the State or agency official acting on behalf of the child) to effectuate the coverage under the Plan.

Clackamas County shall within such time period also provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the Plan, upon receipt of a National Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as in effect immediately before receipt of such National Notice.

13. GENERAL PROVISIONS

13.1 CONFLICTS OF PROVISIONS

In the event that one or more provisions of this document conflict with one or more provisions of any other plan document, the provisions of this document, as from time to time amended, shall control.

13.2 CONTROLLING STATE LAW

To the extent not preempted by federal laws, the laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the Plan.

13.3 DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, the Plan will pay only under the provision allowing the greater benefit. This may require a recalculation based upon both the amounts already paid and the amounts due to be paid. The Plan has NO liability for benefits other than those this Plan provides.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 GENDER AND NUMBER

Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

13.6 HEADINGS

All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth there under.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2. If ERISA does not apply (see section 11.2), the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND PROVISIONS

The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other employee benefits plan maintained by Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Plan. Neither Clackamas County nor Providence Health Plan will have any liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Providence Health Plan. They will assist you in understanding and complying with the terms of the Plan.

13.10 MEMBERSHIP ID CARD

The membership ID card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

13.11 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is nontransferable.

13.12 NO GUARANTEE OF EMPLOYMENT

Neither the maintenance of the Plan nor any part thereof shall be construed as giving any employee covered hereunder any right to remain in the employ of Clackamas County. No shareholder, director, officer, or employee of Clackamas County in any way guarantees to any Member or beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

13.13 NO RECOURSE FOR ACTS OF PROVIDERS

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. Neither Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 NON-WAIVER

No delay or failure when exercising or enforcing any right under this Plan shall constitute a waiver or relinquishment of that right, and no waiver or any default under this Plan shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Plan shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Providence Health Plan, P.O. Box 3125, Portland, OR 97208.

13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly by an Out-of-Network Provider and you pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to Providence Health Plan of the payment. Payment will be made to the Member, subject to written notice of claim, or, if deceased, to the Member's estate, unless payment to other parties is authorized in writing by you. See section 6.1.1 regarding timely submission of claims.

13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. Providence Health Plan, in their discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner considered advisable, to be expended for the person's benefit. PHP's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by Clackamas County and Providence Health Plan.

13.18 PHYSICAL EXAMINATION AND AUTOPSY

When reasonably required for purposes of claim determination, the Plan Sponsor shall have the right to make arrangements for the following examinations, at Plan expense, and to suspend the related claim determination until Providence Health Plan has received and evaluated the results of the examination:

- A physical examination of a Member; or
- An autopsy of a deceased Member, if not forbidden by law.

13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Members, by acceptance of the benefits of this Plan, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or their designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with Providence Health Plan any information relating to any condition for which benefits are claimed under this Plan. Providence Health Plan may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf. If you do not consent to the release of records or to discussions with providers, Providence Health Plan will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

13.20 REQUIRED INFORMATION TO BE FURNISHED

Each Member must furnish to Providence Health Plan such information as they consider necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Member of such true, full and complete information as may be requested.

13.21 RIGHT OF RECOVERY

Providence Health Plan, on behalf of the Plan, has the right, upon demand, to recover payments in excess of the maximum benefits specified in this Plan or payments obtained through fraud, error, or duplicate coverage. If reimbursement is not made to the Plan, Providence Health Plan is authorized by Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 SEVERABILITY

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

13.23 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

- Payment for benefits with respect to a Member under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Member, as required by a State Medicaid Plan;
- The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's enrollment as a Member or beneficiary in the Plan, or in determining or making any payments for benefits of the individual as a Member in the Plan; and
- Payment for benefits under the Plan shall be made to a state in accordance with any state law which provides that the state has acquired the rights with respect to a Member for items or services constituting medical assistance under a State Medicaid Plan.

For purposes of the above, a "State Medicaid Plan" means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

13.24 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees entering into or returning from service in the armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In general, USERRA provides that:

(a) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County to perform services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents) on a self-pay basis. The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section10. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:
    1. The end of the 24-month period beginning on the date on which the employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan sponsored by the Employer with administrative services provided by Providence Health Plan. The funding for the benefits is derived from the funds of the Employer and contributions made by Participants. The Plan is not insured.

This Summary Plan Description constitutes the written instrument under which the Plan is maintained and this document replaces all previous Summary Plan Descriptions. The rights of any person whose employment has terminated, and the rights of such person's covered dependents, will be determined pursuant to the terms of the Plan as in effect on the date such employment terminated, except as may otherwise be specifically provided under the Plan.

14.2 PLAN INFORMATION

Plan Name: Clackamas County Peace Officers Association Open Option Grandfathered Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The Plan Year begins on January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
800-878-4445

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer shall be responsible for all fiduciary functions under the Plan except insofar as any such authority or responsibility is assigned by or pursuant to the Plan to another named fiduciary, or is delegated to another fiduciary by the Employer. The Employer has the discretionary authority to determine eligibility for benefits under the Plan and to interpret the terms of the Plan, unless it has delegated that authority as permitted by the Plan. In the event of such delegation, Providence Health Plan's determinations on the meaning of Plan terms may not be overturned unless found by a court to have been arbitrary and capricious. The allocation of administrative duties and the delegation of discretionary authority for the Plan are specified in the Administrative Services Agreement that has been executed by the Employer and Providence Health Plan.

14.7.1 Complete Allocation of Fiduciary Responsibilities

This section is intended to allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each. The performance of such responsibilities will be deemed a several and not a joint assignment. None of such responsibilities nor any other responsibility is intended to be shared by two or more of them unless such sharing will be provided by a specific provision of the Plan. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two will not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction will be deemed to be its sole responsibility, and the responsibility of the one receiving such direction will be to follow it insofar as such direction is on its face proper under the Plan and applicable law.

14.8 ENGAGEMENT OF ADVISORS

The Employer may employ on behalf of the Plan one or more persons to render advice with regard to any responsibility it may have under the Plan. Toward that end, the Employer may appoint, employ and consult with legal counsel, actuaries, accountants, investment consultants, physicians or other advisors (who may be counsel, actuaries, accountants, consultants, physicians or other advisors for the Employer) and may also from time to time utilize the services of employees and agents of the Employer in the discharge of their respective responsibilities.

14.9 INDEMNIFICATION

The Employer will indemnify its employees for any liability or expenses, including attorneys' fees, incurred in the defense of any threatened or pending action, suit or proceeding by reason of their status as a fiduciary with respect to the Plan, to the full extent permitted by law.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

The Employer reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the Plan, or any document forming part of the Plan.

14.10.2 Manner of Action

Any amendment or termination of the Plan or any part of the Plan shall be made by an instrument in writing reflecting that such change has been authorized by the Employer. Any such amendment or termination shall be effective as of the date specified in said instrument, or, if no date is so specified, as of the date of execution or adoption of said instrument. An amendment may be effected by establishment, modification, or termination of the Plan by appropriate action of the Employer. Any such amendment or termination may take effect retroactively or otherwise. An instrument regarding the establishment, modification or termination of the Plan which is executed by the Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 Effect on Benefits

Claims incurred before the effective date of a Plan change or termination will not be affected. Claims incurred after Plan changes will be covered according to the provisions in effect at the time the claim is incurred. Claims incurred after the Plan is terminated will not be covered. You will not be vested in any Plan benefits or have any further rights, subject to applicable law.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan may disclose de-identified summary health information to the Employer for purposes of modifying, amending or terminating this Plan. In addition, Providence Health Plan may disclose protected health information (PHI) to the Employer in accordance with the following provisions of this Plan as established by the Employer:

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) The Employer shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
(i) The Employer shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
(j) The Employer shall provide for adequate separation between the Employer and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of the Employer:
    1. Directors of Human Resources;
    2. Benefit Managers;
    3. Benefit Analysts;
    4. Benefit Specialists; and
    5. Internal Auditors, when performing Health Plan Audits.

Further, the Employer shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for the Employer with regard to this Plan. In addition, the Employer shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

14.11.2 Security

In accordance with the security standards of the Health Insurance Portability and Accountability Act (HIPAA), the Employer shall:

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

The following are definitions of important capitalized terms used in this Summary Plan Description.

Adverse Benefit Determination
See section 7.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in elective same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the documents with that title that are part of your Plan and summarize the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Chemical Dependency
Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products, or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County Peace Officers Association Open Option Grandfathered Plan

Clackamas County Peace Officers Open Option Grandfathered Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant

See section 4.12.11.

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

Confinement

Confinement means being a resident patient in a Hospital, Skilled Nursing Facility or Qualified Treatment Facility for at least 15 consecutive hours. Successive Confinements are considered to be one Confinement if:

1. Due to the same injury or illness; and
2. Separated by fewer than 30 consecutive days when you are not confined.

Contribution

Contribution means the monetary amount that an Employee is required to contribute as a condition to coverage under the Plan. Specific Contribution amounts are available from your Human Resources office.

Copayment

Copayment means the dollar amount that you are responsible for paying to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary.

Cosmetic Services

Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

1. Listed as a benefit in the Benefit Summary and in section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; and
4. Provided to you while you are a Member and eligible for the Service under this Plan.

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care

Custodial Care means Services that:

1. Do not require the technical skills of a licensed nurse at all times;
2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
3. Are not likely to improve your medical condition.

Such Services will still be considered Custodial Care even if:

1. You are under the care of a physician;
2. The Services are prescribed by a Qualified Practitioner;
3. The Services function to support or maintain your condition; or
4. The Services are being provided by a registered nurse or licensed practical nurse.

Deductible

See section 3.11.1.

Dependent

Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.

Domestic Partner

A Domestic Partner means either of the following:

1. An Oregon Registered Domestic Partner is a person who:
    - Is at least 18 years of age;
    - Has entered into a Domestic Partnership with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
2. A domestic partner who is not an Oregon Registered Domestic Partner is a person at least 18 years of age who:
    - Shares a close personal relationship with a subscriber such that each is responsible for each other's welfare;
    - Is the subscriber's sole domestic partner;
    - Is not married to any person and has not had another domestic partner within the prior six months;
    - Is not related by blood to the subscriber as a first cousin or nearer;
    - Shares with the subscriber the same regular and permanent residence, with the current intention of doing so indefinitely;
    - Is jointly financially responsible with the subscriber for basic living expenses such as food and shelter;
    - Was mentally competent to consent to contract when the domestic partnership began; and
    - Has provided the required employer documentation establishing that a domestic partnership exists.

Note: All provisions of the Plan that apply to a spouse shall apply to a Domestic Partner.

Durable Medical Equipment (DME)

Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

E-mail Visit

E-mail visit (electronic provider communications) means a consultation through e-mail with an In-Network Provider that is, in the judgment of the In-Network Provider, Medically Necessary and appropriate and involves a significant amount of the In-Network Provider's time. An E-mail visit must relate to the treatment of a covered illness or injury (see also section 4.3.3).

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Plan commences for a Member.

Eligibility Waiting Period

Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee

Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Open Option Peace Officers Association Employees, COBRA-participants and non-Medicare eligible Early Retirees.
3. Work Hours: Peace Officers regularly scheduled for at least 20 hours per week. Not applicable to COBRA and Early Retiree.
4. Eligibility Waiting Period: Active -Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of

absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.

8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

The limiting age for each Dependent child is 26 and such children shall become ineligible for coverage on the last day of the month in which their 26th birthday occurs.

A covered Dependent child who attains the limiting age remains eligible if the child is:

a) Developmentally or physically disabled;
b) Incapable of self-sustaining employment prior to the limiting age; and
c) Unmarried.

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under this Plan, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age. Thereafter, Providence Health Plan may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition

See section 4.5.1.

Emergency Medical Screening Exams

See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

Endorsement
Endorsement means a document that amends and is part of this Plan.

Essential Health Benefits
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

Exclusion
Exclusion means an item or service that is not a Covered Service under the Plan.

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are :

- Approved by the appropriate governmental regulatory body;
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient provider in the United States;
- Reviewed and supported by national professional medical societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. Providence Health Plan will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon

request.

Family Member
Family Member means a Dependent who is properly enrolled in and entitled to Covered Services under this Plan.

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

Health Benefit Plan
Health Benefit Plan means any Hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple Employer welfare arrangement or other benefit arrangement defined in the federal Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.11.

Hearing Assistance Technology
See section 4.12.11.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Provider
Home Health Provider means a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

Hospital
Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home,

Skilled Nursing Facility, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Substance Abuse or Mental Health disorders.

In-Network Provider

In-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

In-Plan

In-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services that are provided by an In-Network Provider.

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

Medically Necessary

Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by Providence Health Plan.

The criteria are based on the following principles:

1. Covered Services are determined to be Medically Necessary if they are health care services or products that a Qualified Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing, preventing, or treating illness (including mental illness), injury, disease or its symptoms, and that are:
    a. In accordance with generally accepted standards of medical practice;
        i. Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Qualified Practitioner specialty society recommendations, the views of Qualified Practitioners practicing in relevant clinical areas, and any other relevant factors;
    b. Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the Member's medical condition;
    c. Not primarily for the convenience of the Member or Qualified Practitioner; and
    d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's illness, injury or disease.

Prudent Clinical Judgment: The "prudent clinical judgment" standard of Medical Necessity ensures that Qualified Practitioners are able to use their expertise and exercise discretion, consistent with good medical care, in determining the Medical Necessity for health care services to be provided to each Member. Covered Services may include, but are not limited

to, medical, surgical, diagnostic tests, substance abuse treatment, other health care technologies, supplies, treatments, procedures, drug therapies or devices.

Member
Member means a Subscriber or Eligible Family Dependent, who is properly enrolled in and entitled to Services under this Plan.

Mental Health
Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, during which Eligible Employees are given the opportunity to enroll themselves and their Dependents under the Plan for the upcoming Plan Year, subject to the terms and provisions as found in this Summary Plan Description.

Out-of-Network Provider
Out-of-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital, Skilled Nursing Facility, or Pharmacy that does not have a written agreement with Providence Health Plan to participate as a health care provider for this Plan.

Out-of-Plan
Out-of-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services provided by Out-of-Network Providers.

Out-of-Pocket Maximum
See section 3.11.2.

Outpatient Surgical Facility
Outpatient surgical facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Pharmacy
Participating Pharmacy means pharmacy that has a signed contract with Providence health Plan to provide medications and other Services at special rates. There are four types of Participating Pharmacies:

1. Retail: A Participating Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.

2. Preferred Retail: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
3. Specialty: A Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
4. Mail Order: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Plan

Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary and any Endorsements, amendments and addendums that accompany this document.

Plan Administrator

Plan Administrator means the "Administrator" or "Plan Administrator" as those terms are defined under ERISA and shall refer to the current or succeeding person, committee, partnership, or other entity designated as such by the terms of the instrument under which the Plan is operated, or by law. Regardless of the terms of the instrument under which the Plan is operated, Providence Health Plan is not the Plan Administrator.

Plan Year

Plan Year means a 12-month time period beginning January 1st and ending December 31st.

Primary Care Provider

Primary Care Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician who agrees to be responsible for the Member's continuing medical care by serving as case manager. Members may also choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

(Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the Provider Directory online or call Customer Service.)

Prior Authorization

Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.5.

Prior Authorized determinations are not a guarantee of benefit payment unless:

- A determination that relates to benefit coverage and medical necessity is obtained no more than 30 days prior to the date of the Service; or
- A determination that relates to eligibility is obtained no more than five business days prior to the date of the Service.

Providence Health Plan
Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon and Washington that serves as the claims administrator with respect to this Plan.

Qualified Practitioner
Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery
Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic
Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket, or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified as a "Skilled Nursing Facility" by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Spouse
Spouse means an individual who is legally married to the Subscriber in accordance with the laws of the country or state of celebration.

Subscriber
Subscriber means an employee or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this

Summary Plan Description.

Summary Plan Description (SPD)

Summary Plan Description (SPD) means the description of the Plan as contained in this document, and includes the provisions of any Benefit Summary, any Endorsements, amendments and addendums that accompany this document, and those policies maintained by Providence Health Plan which clarify any of these documents.

Termination Date of Coverage

Termination Date of Coverage means the date upon which coverage under this Plan ends for a Member. No coverage under the Plan will be provided beyond the Termination Date of Coverage.

Urgent Care

Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.

Urgent Care Covered Services are provided when your medical condition meets the guidelines for Urgent Care that have been established by Providence Health Plan. Covered Services do NOT include Services for the inappropriate use of an Urgent Care facility, such as: services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)

When a Service is provided by an In-Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with In-Network Providers for that Service. UCR charges will never be less than Providence Health Plan's negotiated fees.

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Virtual Visit

Virtual Visit means a visit with a Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network or Out-of-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife, or licensed direct entry midwife practicing within the applicable lawful scope of practice.

16. NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث ذكر 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 می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

ADOPTION OF THE SUMMARY PLAN DESCRIPTION AS THE PLAN DOCUMENT

Adoption

On the date shown, below, the Plan Sponsor hereby adopts this Summary Plan Description and the Benefit Summaries, Endorsements and amendments which are incorporated by reference, as the Plan Document of the Clackamas County self-funded Employee Health Benefit Plan, Clackamas County Peace Officers Association Open Option Grandfathered Plan. This document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for Clackamas County's Eligible Employees and Eligible Family Dependents. Those benefits are described in this Summary Plan Description.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed, effective as of January 1, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); or one of our Sales representatives at 503-574-6300 or 877-245-4077, 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

Clackamas Co POA Open Option GF SPD
Effective January 01, 2021
Administered by Providence Health Plan

2021 Summary Plan Description

Peace Officers Association

Personal Option Grandfathered

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County has contracted with Providence Health Plan to process claims and provide customer service to Plan Members. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Mail order prescription drug services	ProvidenceHealthPlan.com
Medical, Mental Health, and Chemical Dependency Prior Authorization requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION PERSONAL OPTION GRANDFATHERED PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us" or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
  - Our Providence Signature Network of In-Network Providers; and
  - Providence Health Plan's national network of In-Network Providers.
- Covered Services must be obtained from In-Network Providers, with the following exceptions:
  - Emergency Services and Urgent Care Services, as specified in section 4.5;
  - Covered Services received by an enrolled Out-of-Area Dependent, as specified in section 3.5.2; and
  - Covered Services delivered by an Out-of-Network Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.7.
- All Members are encouraged to choose a Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of In-Network Providers in our Service Area and our national In-Network Providers is available at ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 3.7.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in Plan documents. You should read the provisions, limitation and exclusions before seeking Covered Services because not all health care services are covered by this Plan.
- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan's policies.

1.2 GRANDFATHERED PLAN NOTICE

This Employer Group believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of PPACA that apply to other Plans, for example, the requirement for the coverage of certain preventive health care services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of the lifetime maximum benefit.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or human resources department.

Non-ERISA plans: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. Our goal is to help improve the health status of individuals in the communities in which we serve. This booklet contains important information about the health plan coverage offered to Clackamas County Peace Officer Association Employees and their Dependents.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. Our goal is to help improve the health status of individuals in the communities in which we serve. This booklet contains important information about the health plan coverage offered to Clackamas County Peace Officer Association Employees and their Dependents.

2.1 CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION PERSONAL OPTION GRANDFATHERED PLAN

Your Plan allows you to receive Covered Services from In-Network Providers.

It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is an In-Network Provider and whether or not the health care is a Covered Service even if you have been directed or referred for care by an In-Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit our Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, before you make an appointment. You can also call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

Whenever you visit a Provider:

- Bring your Providence Health Plan Member ID Card with you.
- Be prepared to make a Copayment at the time of visit if the office visit is subject to a Copayment.
- If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be able to pay for what you owe at the time of your visit. Your provider's office will send you a bill for what you owe later. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and bill or credit you for the balance later.

2.2 SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains important information about the health plan coverage offered to employees of Clackamas County. It is important to read this Summary Plan Description carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 15. If you need additional help understanding anything in this Summary Plan Description, please call Customer Service at 503-574-7500 or 800-878-4445. *See section 2.3 for additional information on how to reach Customer Service*.

This Summary Plan Description is not complete without your:

- **Clackamas County Peace Officers Association Personal Option Grandfathered Plan Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide other important information.

- **Provider Directory** which lists In-Network Providers, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need detailed information for a specific problem or situation, contact your Employer or Customer Service.

2.3 CUSTOMER SERVICE

We want you to understand how to use your Providence Health Plan benefits and to be satisfied with your health plan coverage. Customer Service is available to assist you in understanding your benefits and resolving any problems you may have, including:

- Specific benefit or claim questions.
- Questions or concerns about your health care or service.

Contacting Providence Customer Service

Customer Service representatives are available by phone from 8 a.m. to 5 p.m., Monday through Friday, (excluding holidays). **Please have your Member ID Card available when you call:**

- **Members in the Portland-metro area, please call 503-574-7500.**
- **Members in all other areas, please call toll-free 800-878-4445.**
- **Members with hearing impairment, please call the TTY line 711**

You may **access claims and benefit information 24 hours a day, seven days a week** online through your myProvidence account.

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Summary Plan Description and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768.

2.5 YOUR MEMBER ID CARD

Each Member of Providence Health Plan receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member number and group number
- Important phone numbers

The Member ID Card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your Member ID Card, and pay your Copayment or Coinsurance.

Please keep your Member ID Card with you and use it when you:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse Customer Service.
- Call or correspond with Customer Service.
- Call Providence nurse advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.

2.6 PROVIDENCE NURSE ADVICE LINE

503-574-6520; toll-free 800-700-0481; TTY 711

The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6, for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching

Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for tobacco-use cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

Quit for Life can be reached at 866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See Registering for a myProvidence account, section 2.4, for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America
Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services for Providence Health Plan members. Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program. Please have your Providence Health Plan Member ID card ready, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information," we mean information that identifies you as an individual (such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain their medical records from their provider. Call your physician's or provider's office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represents a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan.

Providence Health Plan may disclose a Member's PHI to an employer or any agent of the Employer if the disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it.

3. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Primary Care Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing.

This section describes how to use this Plan and how benefits are applied. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is an In-Network Provider even if you have been directed or referred for care by an In-Network Provider.

3.1.1 Nationwide Network of In-Network Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services when using In-Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing an In-Network Provider

To choose an In-Network Provider, or to verify if a provider is an In-Network Provider, please refer to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

Your In-Network Provider will work with Providence Health Plan to arrange for any Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.7.

3.1.3 Indian Health Services Providers

Native American Indian and Alaskan Native Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from an In-Network Provider. For a list of IHS facilities, please visit the IHS website at www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend that upon joining Providence Health Plan you and each of your Family Members choose an In-Network Primary Care Provider as soon as possible.

3.2.1 Primary Care Providers

A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider.

Primary Care Providers provide preventive care and health screenings, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Primary Care Providers offer maternity care and minor outpatient surgery as well.

IMPORTANT NOTE: In-Network Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our In-Network Providers with the specialties listed above are In-Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated In-Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend that you choose a Primary Care Provider from our Provider Directory, available online, for each covered Family Member. Call the provider's office to make sure they are accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

- What are the office hours?
- How can I get medical advice after hours?
- What do I do in an emergency?

Let your Primary Care Provider know if you are under a specialist's care as well as if you are

currently taking any ongoing prescription medications.

3.2.4 Changing Your Primary Care Provider

You are encouraged to establish an ongoing relationship with your Primary Care Provider. If you decide to change your Primary Care Provider, please remember to have your medical records transferred to your new Primary Care Provider.

3.2.5 Office Visits

Primary Care Providers

We recommend you see your Primary Care Provider for all routine care and call your Primary Care Provider first for urgent or specialty care. If you need medical care when your Primary Care Provider is not available, the physician/provider on call may treat you and/or recommend that you see another provider for treatment.

Specialists

Your Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a specialist for treatment.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who is an In-Network Provider with Providence Health Plan.

If you decide to see a specialist on your own, we recommend you let your Primary Care Provider know about your decision. Your Primary Care Provider will then be able to coordinate your care and share important medical information with your specialist. In addition, we recommend you let your specialist know the name and contact information of your Primary Care Provider.

Whenever you visit a specialist:

- Bring your Providence Health Plan Member ID Card.
- Understand that in most cases, your out-of-pocket costs will be a percent of the charges for services. Your provider's office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and will bill or credit you the balance later. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Chiropractic Care Providers

This Plan includes coverage for specified chiropractic services. See section 4.15 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

Providence Health Plan may approve and provide reimbursement for Out-of-Network Qualified Practitioners and facilities. Benefits for Covered Services by an Out-of-Network provider will be provided as shown in the Benefit Summary when we determine in advance,

in writing, that the Out-of-Network Provider possesses unique skills which are required to adequately care for you and are not available from In-Network Providers.

Under no circumstances (with the exception of Emergency and Urgent Care) will we cover Services received from an Out-of-Network Provider/Facility unless we have Prior Authorized the Out-of-Network Provider/Facility and the Services received.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If the approved, Prior Authorized Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Provider, those Services are still subject to the terms of this Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

It is important for you to understand that Providence Health Plan has not assessed the approved, Prior Authorized Out-of-Network Provider's credentials or quality; nor has Providence Health Plan reviewed and verified the Out-of-Network Provider's qualifications and history for information such as: relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Additionally, the Out-of-Network Provider will not have been assessed by Providence Health Plan to verify that the provider meets certain criteria relating to professional competence and conduct and as such is not guaranteed to follow your benefit plan, rules, regulations, or guidelines with regard to standards of care nor standards of documentation and billing.

Payment for Out-of-Network Physician/Provider Services (UCR)

If the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Plan benefits as shown in the following example (amounts shown are only estimates of what may apply).

	Provider's Status	
Item	In-Network	Out-of-Network
Provider's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount that the provider may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.

Payment for Covered Services Provided Before Disposition of Criminal Charges

If you are in the custody of an Oregon state or local corrections agency pending the disposition of criminal charges brought by an Oregon county, we will reimburse the custodial county for the costs of Covered Services or supplies rendered before the disposition of charges, in an amount that is no less than 115 percent of the Medicare rate for the service or supply, except for renal dialysis which will be reimbursed in accordance with the terms of the Plan for Out-of-Plan dialysis providers.

The following Services and Supplies are excluded from coverage under this section:

- Diagnostic tests or health evaluations required by the corrections agency, as a matter of course, for all individuals who are in the custody of the county pending the disposition of charges;
- Hospital and ambulatory surgical center services, except as rendered by an In-Plan provider.

3.4 MOVING INTO OR OUT OF THE SERVICE AREA

If you or a Family Member permanently moves into or out of the Service Area, you must immediately notify us and your Employer as such a move may affect your benefits or coverage under this Personal Option Plan. We will determine how this move affects your coverage and will inform you of any changes. If you have Dependent(s) who move in or out of our Service Area, a Change of Status form for those Dependent(s) must be completed and returned to us as soon as possible. This form can be obtained from us or from your Employer. See section 8.2.6 for more information.

3.5 OUT-OF-AREA DEPENDENTS

Dependents of a subscriber on a Personal Option Plan who live outside the Providence Health Plan Service Area (including dependents who are away at school) are eligible to become Out-of-Area Dependent Members. See "Definitions" section 15, for the definition of "Eligible Family Dependent" and "Out-of-Area Dependent." **This section discusses how Enrolled Out-of-Area Dependent Personal Option Plan Members obtain covered services through Providence Health Plan's enrolled Out-of-Area Dependent benefit.**

3.5.1 Out-of-Area Dependent Enrollment

To apply for Personal Option Out-of-Area Dependent benefits, complete an Out-of-Area Dependent Enrollment form, available from your Customer Service team. **If you do not complete an Out-of-Area Dependent Enrollment form, your Out-of-Area Dependent will not be covered for Out-of-Area Dependent benefits.**

3.5.2 Out-of-Area Dependent Coverage

When you enroll for Out-of-Area Dependent coverage, we will send you an Out-of-Area Dependent Benefit Summary. As stated in your Benefit Summary, a Dependent with Out-of-Area benefits may see any provider, in or out of the Service Area. Please refer to your Out-of-Area Dependent Benefit Summary for detailed Coinsurance or Copayment and annual Out-of-Pocket Maximum information. (For Out-of-Area Dependents who are covered by a government sponsored health plan of a county other than the United States, coverage under this Personal Option Out-of-Area Dependent plan will be secondary and will not replace or duplicate coverage available under the government sponsored plan.) Our payment is based on usual, customary and reasonable (UCR) charges. Charges which exceed UCR charges are your responsibility.

You must purchase your prescription drugs at one of our nationwide Participating Pharmacies (see section 4.14.1). A list of our Participating Pharmacies is available online at www.ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Participating Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Copayment and Coinsurance, if applicable, and on how to use this benefit.

3.5.3 Out-of-Area Dependents and Change of Status

Enrolled Out-of-Area Dependents may change to In-Area or Out-of-Area status by contacting us and completing a status change enrollment form. The change will be effective the date you specify or if no date is specified, on the first of the month following our receipt of the enrollment form. Retroactive changes are limited to 30 days.

3.5.4 Out-of-Area Dependents Prior Authorization

Enrolled Out-of-Area Dependents are responsible for obtaining Prior Authorization from Providence Health Plan prior to receiving certain services from Out-of-Network Providers. For further information about Prior Authorization, including a list of these Covered Services and how to obtain Prior Authorization, see section 3.7.

You must contact us to obtain Prior Authorization for specified Covered Services if the Services are to be received from an Out-of-Network Provider. See section 3.7.

3.6 NOTICE OF PROVIDER TERMINATION

When an In-Network Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within 10 days of the termination date or of our knowledge of the termination date.

3.7 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from In-Network Providers:
When Services are received from an In-Network Provider, the In-Network Provider is responsible for obtaining Prior Authorization.

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.8.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health, and Substance Abuse, as provided in sections 4.10.1 and 4.10.2.
- All Applied Behavior Analysis, as provided in section 4.10.3.
- All Human Organ/Tissue Transplant Service, as provided in 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.
- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.

- Certain medications, including certain immunizations, received in your Provider's office, as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

Providence Health Plan will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call Customer Service at the number listed on your Member ID Card.

If an Emergency Medical Condition exists which prevents you from obtaining Prior Authorization, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

Prior Authorization Requests for Out-of-Plan Services:
The Member or the Out-of-Network Provider must call us at 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:
The Member's name and date of birth.

- The Member's Providence Health Plan Member number and Group number (these are listed on your Member ID card).
- The Provider's name, address and telephone number.
- The name of the Hospital or treatment facility.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

Failure to Obtain Prior Authorization:
If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty**, not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Out-of-Pocket Maximum shown in the Benefit Summary.

3.8 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.9 MEDICAL COST MANAGEMENT

Coverage under this Plan is subject to the medical cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

The Plan reserves the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by Providence Health Plan. When more than one medically appropriate alternative is available, Providence Health Plan will approve the least costly alternative.

In accordance with Providence Health Plan's medical cost management protocols and criteria specified in this paragraph, Providence Health Plan may approve substitutions for Covered Services under this Plan.

A Substituted Services must:

1. Be Medically Necessary;
2. Have your knowledge and agreement while receiving the Service;
3. Be prescribed and approved by your Qualified Practitioner; and
4. Offer a medically therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

The Plan's coverage of a Substituted Service for any Member does not obligate the Plan to:

- Cover a Substituted Service for any other Member;
- Continue to cover a Substituted Service beyond the term of the agreement between the Plan and the Member; or
- Cover any Substituted Service for the Member, other than as specified in the agreement between the Plan and the member.

Substituted Services that satisfy the requirements of this section are Covered Services for all purposes under this Plan.

A Substituted Service may be disallowed at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.

3.9.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

Providence Health Plan has developed standards to guide the evaluation process and to

ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage:

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

A committee of medical directors with physician specialist advisors evaluates all new technology and determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services that provide independent analysis of a new technology.

Expedited Review

Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 7.

3.10 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.

- ***Example:*** *Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.*
- ***Example:*** *You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor's office. The Plan would not pay for that visit.*
- ***Example:*** *You stay an extra day in the hospital only because the relative who will help you during recovery cannot pick you up until the next morning. We may not pay for the extra day.*

Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.11 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial offered through an In-Network provider.

Covered Services include the routine patient costs for items and services received from In-Network providers and facilities in connection with the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services under the Plan.

You may choose to participate in an Approved Clinical Trial offered through an Out-of-Network provider, however, coverage will only be provided for Medically Necessary services received In-Network in treatment of an illness or injury.

The following costs are excluded:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- The cost for any services received Out-of-Network.

The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for services unrelated to a clinical trial to the extent that the services are otherwise Covered Services under the Plan.

3.12 HOW BENEFITS ARE APPLIED

Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:

1. The Copayment or Coinsurance amount; and
2. The benefit limits and/or maximums.

3.13 OUT-OF-POCKET MAXIMUMS

Your Plan has an Out-of-Pocket Maximum, as stated in your Benefit Summary.

3.13.1 Understanding Out-of-Pocket Maximums

Out-of-Pocket Maximums are the total amount you will pay out-of-pocket in any Calendar Year for Covered Services received under this Plan. See your Benefit Summary.

***Individual Out-of-Pocket Maximum*:** Individual Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

***Family Out-of-Pocket Maximum*:** Family Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family of three or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment and Coinsurance expenses of enrolled Family Members meet the family Out-of-Pocket Maximum, all remaining individual

Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Note: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

***Your Costs that Do Not Apply to Out-of-Pocket Maximums*: The following out-of-pocket costs do not apply toward your Individual and Family Out-of-Pocket Maximums:**

- Services not covered by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

IMPORTANT NOTE: Some Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services, as shown in the Benefit Summary, remains in effect throughout the Calendar Year.

4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

You must use In-Network Providers to receive the Covered Services listed in this section, unless you are an Enrolled Out-of-Area Dependent or have received Prior Authorization to receive services from an Out-of-Network Provider.

Benefits are provided for preventive care and for the treatment of illness or injury when such treatment is Medically Necessary and provided by a Qualified Practitioner as described in this section and shown in the Benefit Summary.

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4.2.

In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, http://www.hrsa.gov/womens-guidelines.

Note: Additional Plan provisions apply to some Services (e.g., routine physical examinations and well-baby care must be received from an In-Network Primary Care Provider, see section 4.1.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered only when received from an In-Network Primary Care Provider. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

Infants up to 30 months:	Up to 12 well-baby visits.
Children and Adolescents:	
3 years through 21 years:	One exam every year.
Adults:	
22 years through 29 years:	One exam every five years.
30 years through 49 years:	One exam every two years.
50 years and older:	One exam every year.

If, at the time of your routine physical examination or well-child care, you need paperwork completed for a third party, such as school, camp, team sports, etc., your provider may charge you a fee to complete the paperwork. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, except as specified in section 4.12.11.

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.

4.1.3 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by a Qualified Practitioner for men designated high risk.

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members age 50 and older include:

- One fecal occult blood test per year, plus one sigmoidoscopy every five years; or
- One colonoscopy every 10 years; or
- One double contrast barium enema every five years.

Screening examinations and lab tests for Members designated high risk are covered as recommended by the Qualified Practitioner.

For Members age 50 and older:

- All Services for colorectal cancer screenings and exams are covered in full.

For Members under age 50:

- All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.

4.1.5 Preventive Services for Members with Diabetes

Preventive Services benefits for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- A dilated retinal exam by a qualified eye care specialist every Calendar Year;
- A glycosylated hemoglobin (HbA1c) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth (dental visits are not covered); foot inspection; and influenza vaccine by a Qualified Practitioner every Calendar Year; and
- A pneumococcal vaccine every five years.

4.1.6 Diabetes Self-Management Education Program

Benefits are paid in-full for diabetes self-management education programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes as prescribed by a Qualified Practitioner. “Diabetes self-management program” means one program of assessment and training after diagnosis as well as assessment and training upon a material change of condition, medication or treatment. All services must be received from licensed providers and facilities, practicing within scope of license.

4.1.7 Nutritional Counseling

A maximum of two visits per Calendar Year are covered for nutritional counseling when Medically Necessary, as determined by the Qualified Practitioner. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services

Coverage is provided for participation in a Providence Health Plan-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. "Tobacco use cessation program" includes educational and medical treatment components such as, but not limited to, counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of Providence Health Plan-approved programs is available online at www.ProvidenceHealthPlan.com (select "search" and enter "tobacco cessation") or by calling Customer Service at 503-574-7500 or 800-878-4445.

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners, certified nurse midwives, and licensed direct entry midwives.

4.2.1 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and Pap examinations once every Calendar Year or more frequently for women who are designated high risk. Family planning Services are separate (see section 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider.

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Lactation Counseling Services must be received from licensed providers. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through In-Network Medical Equipment Providers.

4.2.4 Family Planning Services

Benefits include counseling, exams, and services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and

- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Participating Pharmacy.

Services are covered in full and must be received from In-Network Providers and Facilities. Oral contraceptives must be purchased at Participating Pharmacies.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.10.

4.3 PROVIDER SERVICES

4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Some services provided by your Qualified Practitioner during your visit may result in additional Member financial responsibility.

For example – You see your Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific services, such as allergy shots, maternity care, and diagnostic services. See your Benefit Summary for details.

If you are unable to keep a scheduled office appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Providence Health Plan will not cover this expense.

4.3.2 Virtual Visits

The Plan provides coverage for the following types of Virtual Visits with In-Network Providers using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers who may be approved for E-mail Visits. In-Network Providers who are authorized to provide E-mail Visits have agreed to use Internet security technology approved by us to protect your information from unauthorized access or release. To be eligible for the E-mail Visit benefit,

you must have had at least one prior office visit with your In-Network Provider within the last 12 months.

Covered E-mail Visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by the Plan;
- Communications by the In-Network Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of e-mail communications that do not qualify as E-mail Visits include, but are not limited to:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
- All communications in connection with Mental Health or Substance Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service:

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that

allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site.

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

4.3.7 Immediate Care

Immediate Care is an extension of your Primary Care Provider's office, and provides additional access to treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care or, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Immediate Care Provider.

4.3.8 Retail Health Clinic

Coverage is provided as shown in the Benefit Summary for Covered Services obtained at Retail Health Clinics. Retail Health Clinics can provide diagnosis and treatment services for uncomplicated minor illnesses and injuries, like sore throats, ear aches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

4.4 DIAGNOSTIC SERVICES

Coverage is provided as shown in your Benefit Summary for Diagnostic Services.

4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

4.4.2 Sleep Study Services

Benefits include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

Benefits for Emergency Services and Urgent Care Services are provided as described below and shown in your Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

4.5.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Medically necessary detoxification
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Unexpected premature childbirth

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:

"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical

attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child.

"Emergency Services" means, with respect to an Emergency Medical Condition:

- An Emergency Medical Screening Exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"Emergency Medical Screening Exams" include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition**, call 911 or go to the nearest emergency room.** Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card.

Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care.

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility

are covered in full.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

4.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary emergency care or to a facility specified by Providence Health Plan. Air ambulance transportation is only covered for a life-threatening medical emergency, or when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time. Ambulance transportation solely for personal comfort or convenience is not covered.

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions resulting from an injury to or illness of the eye(s). Members may receive Services directly from an optometrist or ophthalmologist or from a Hospital emergency room.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their office is not Urgent Care.

Whenever you need urgent care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Qualified Provider.

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

When you are admitted to an Out-of-Network Hospital from an Urgent Care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

Not all Out-of-Network facilities will file a claim on a Member's behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services.
Covered Services do NOT include care received that consists primarily of:

- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases, the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

- Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to a Network Hospital.

For Enrolled Out-of-Area Dependents: You are responsible for making sure inpatient hospitalization services are Prior Authorized by Providence Health Plan before receiving this care from an Out-of-Network Hospital.

Only Medically Necessary hospital services are covered. Covered inpatient Services received in a Hospital are:

- Acute (inpatient) care;

- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care, and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by Providence Health Plan and prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary.

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitation benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.2 for coverage of Outpatient Rehabilitative Services.)

4.6.4 Inpatient Habilitative Care

Coverage is provided for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24 - 48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy, and Multidisciplinary Pain Management Programs

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.7.

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity.

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.11.

See section 4.6.3 for coverage of Inpatient Rehabilitative Services.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as stated in the Benefit Summary, for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits, and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

<u>Covered Services include:</u>

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care*.
- Newborn nurse home visits**.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit.

**Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services.

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

The services of a lay, unlicensed direct entry, certified professional, or any other unlicensed midwife are not covered.

Length of maternity hospital stay: Your services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery, and a minimum of 96 hours for a Caesarean delivery. You will not be discharged from the hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

Maternity support services: Members may attend a class to prepare for childbirth. The classes are held at Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

Diabetes coverage during pregnancy: During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Plan.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME)

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) are provided as shown in the Benefit Summary when required for the standard treatment of illness of injury. Providence Health Plan may authorize the purchase of an item if they determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by a Qualified Practitioner.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or more efficient model are not covered unless Medically Necessary. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.

4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

Benefits are provided as shown in the Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances, including Hearing Aids and Hearing Assisted Technology (HAT) as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary

and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck; or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 4.9.2).

4.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by Providence Health Plan.

Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;

- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program;
- Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

An approved ABA treatment plan is subject to review by us, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

4.10.3 Substance Abuse Services

Benefits are provided for Substance Abuse Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan.

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.11 HOME HEALTH AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and are described below. The Plan will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Plan.

Any visit by a person providing Services under a home health care plan, or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency. If you were hospitalized immediately prior to the commencement of home health care, the home health care plan must be initially approved by the Qualified Practitioner who was the primary provider of Services during the hospitalization.

If the above criteria are not met, NO benefits will be provided under this Plan for home health care.

Rehabilitation services provided under an authorized home health care plan will be covered as home health care Services.

Home health care benefits do NOT include:

1. Charges for mileage or travel time to and from your home;
2. Wage or shift differentials for Home Health Providers;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services include the following:

- Nursing care provided by or under the supervision of a registered nurse;

- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7.

All Direct-to-Consumer genetic tests are considered investigational and are not covered.

4.12.2 Inborn Errors of Metabolism

The Plan will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, spinal fluid, or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.

4.12.5 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

- Reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;

- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in 4.12.7.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services from an In-Network Provider as shown in the Benefit Summary. Covered Services include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic X-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 4.9.2 (Medical Appliances). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and
6. Surgical Services.

TMJ Services are covered as shown in your Benefit Summary; limits may apply.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered under your Prescription Drug benefit when received from a Participating retail or specialty Pharmacy as shown in the Benefit Summary (See section4.14).

4.12.9 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.10 Elective Sterilization

Coverage is provided, as stated below, for voluntary sterilization (tubal ligation and vasectomy).

All Covered Services must be received from Qualified Providers and Facilities.

- Services are covered in full and must be received from Network Providers and Facilities. Oral contraceptives must be purchased at Network Pharmacies.

Please note: Providence Health Plan is a Catholic-sponsored health plan, and, as a matter of conscience, Providence Health & Services facilities do not offer these Services. Services are available at other Network facilities.

4.12.11 Hearing Loss Services

Definitions:

Cochlear Implant

Cochlear Implant means a device that can be surgically implanted under the skin in the bony area behind the ear (the cochlea) to stimulate hearing.

Hearing Aid

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries, or accessory for the instrument or device, except cords.

Covered Services:

The following hearing loss services are covered under this Plan as described below. Benefits for such services are provided at the applicable benefit level for that particular type of service, as listed in your Benefit Summary.

All Covered Services must be Medically Necessary and appropriate, and prescribed, fitted, and dispensed by a licensed audiologist, hearing aid/instrument specialist, or other Qualified Practitioner.

Cochlear implants:

Cochlear implants for one or both ears, including programming, reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.

Hearing aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and

dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year.

Diagnostic & Treatment Services

Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit.

Hearing Assistance Technology:

- Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.

Limits to Hearing Loss Services

Coverage for hearing loss services are provided in accordance with state and federal law.

4.12.12 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person's body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;

2. Are provided at a facility approved by us or under contract with Providence Health Plan;
3. Involve one or more of the following organs or tissues:
    - Heart
    - Lung
    - Liver
    - Kidney
    - Pancreas
    - Small bowel
    - Autologous hematopoietic stem cell/bone marrow
    - Allogeneic hematopoietic stem cell/bone marrow; and
4. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel expenses are not covered for donors.)

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other Health Benefit Plan or government funding program. Covered Services for donors include:

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Member/recipient is responsible for the Coinsurance or Copayment amounts for pre-transplant services and post-transplant services at the applicable Inpatient Hospital Services and Outpatient Facility Services benefit.

The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition, and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.

The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the, Coinsurance or Copayment amounts for those Services, as shown in the Benefit Summary, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member's Out-of-Pocket Maximum.

4.13.5 Transplant Prior Authorization

(See also section 3.5.)
To qualify for coverage under this Plan, all transplant-related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant;
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by Providence Health Plan;
- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions.

Prescription Drug Definition

The following are considered "Prescription Drugs":

1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription";
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal or state legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Evidence Review as effective for the treatment of a particular indication.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

You have access to Providence Health Plan's nationwide broad pharmacy network as published in our pharmacy directory.

Providence Health Plan Participating Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at www.ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.
- Participating Pharmacies may not charge you more than your Copayment or Coinsurance. Please contact Customer Service if you are asked to pay more or if you, or the pharmacy, have questions about your Prescription Drug Benefit or need assistance processing your prescription.

- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drugs at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at www.ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies.)
- Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network Pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. Reimbursement is subject to your Plan's limitations and exclusions. You are responsible for

any amounts above our contracted rates.

International prescription drug claims will only be covered when prescribed for emergent conditions and will be subject to your medical Emergency Services benefit and any applicable Plan limitations and exclusions.

4.14.3 Prescription Drug Formulary

The Formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives. The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices to treat most medical conditions.

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See Section 6.1 under Claims Involving Prior Authorization and Formulary Exception.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the Formulary for your Plan, visit https://healthplans.providence.org/members/pharmacy-resources/.

4.14.4 Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.

If you request a brand-name drug, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed

a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Participating Pharmacies; and
6. Opioids up to 7 days initial dispensing.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs are those you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.
3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If Providence Health Plan removes a pharmacy from its network, we will notify you of this change at least 30 days in advance. Notification may be done via the online directory or letter depending on the circumstance.

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the

Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.

4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.
7. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
8. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug Exclusions

In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows:

1. Drugs or medicines delivered, injected or administered to you by a physician, other provider or another trained person (see section 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 10 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Drugs prescribed by naturopathic physicians (N.D.);
9. Over-the-counter (OTC) drugs or vitamins, that may be purchased without a provider's written prescription, except as required by federal or Oregon state law;
10. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
11. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions or as required by federal or Oregon state law;
12. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
13. Replacement of lost or stolen medication;
14. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);

15. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
16. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g. gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs used for weight loss or for cosmetic purposes;
20. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
21. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
22. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.

4.14.9 Prescription Drug Disclaimer

Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

4.15 CHIROPRACTIC CARE BENEFIT

The Chiropractic Care Supplemental Benefit provides coverage for Services received from Chiropractic Care Providers provided that the Services are Medically Necessary and are within the scope of practice of the provider involved in your care.

All Chiropractic Care benefits are subject to any conditions and benefit limits stated in your Chiropractic Care Benefit Summary and in this section.

All chiropractors must be licensed in the state in which they practice and must practice within the scope of their license.

4.15.1 Chiropractic Care Providers

All Members must receive Covered Services from our nationwide network of Network chiropractors. To find a chiropractic care In-Network Provider in your area, visit our website at ProvidenceHealthPlan.com/findaprovider or call Customer Service.

You do not need a physician's referral to see a chiropractor.

In rare circumstances, our national network may not include a Network chiropractor in your area. If this happens, please contact Customer Service before making an appointment. If Customer Service is unable to locate an In-Network Provider within a reasonable distance, authorization for use of an Out-of-Network Provider will be provided.

In some cases, you will need to pay the Out-of-Network Provider directly for the care you receive, and then submit your itemized billing statement to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

Reimbursement for services from Out-of-Network Providers is subject to Plan approval. The Plan will reimburse you the cost of your services at a Usual, Customary and Reasonable rate, less your applicable Copayment or Coinsurance. You will be responsible for all amounts over the UCR.

4.15.2 Chiropractic Care Services

Covered Services from chiropractors:

- Office visits.
- Chiropractic manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are Medically Necessary for the treatment of neuromusculoskeletal disorders.
- Related diagnostic X-rays and laboratory Services.

The following services are NOT covered from chiropractors:

- Preventive care services.
- Services, exams and/or treatments for conditions other than neuromusculoskeletal disorders.
- All chiropractic appliances or Durable Medical Equipment.
- Adjunctive physiotherapy not associated with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor's office.
- Venipuncture.
- Services received from a chiropractor that are not listed as a Covered Service.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Education programs, self-care or self-help programs or any self-help physical exercise training or any related diagnostic testing.
- Transportation costs including local ambulance charges.
- Massage therapy.
- Thermography.
- Therapeutic modalities and procedures that are considered by us or our authorizing agent to be invasive.
- Emergency care and Urgent/Immediate care services.
- Any service or supply that is not permitted by state law with respect to the chiropractor's scope of practice.
- Services in excess of the benefit limits listed in the Chiropractic Care Supplemental Benefit Summary.
- Services received from Out-of-Network Providers, except as discussed in this section.

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, the following are specifically excluded from coverage under this Plan.

General Exclusions:

The Plan does not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition).

The Plan does not cover:

- Charges that are in excess of the Usual, Customary, and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as covered in section 4.3.2.
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.8 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;

- Recreation services, therapeutic foster care, and wraparound services; emergency aid for household items and expenses; services to improve economic stability, and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of licensed acupuncturists, a physician performing acupuncture Services, naturopathic physicians, chiropractic physicians and licensed massage therapists, except as provided in section 14.15;
- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;
    - All services related to artificial insemination, including charges for semen harvesting and storage;
    - Diagnostic testing and associated office visits to determine the cause of infertility;
    - All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
        - Physical examination;
        - Related laboratory testing;
        - Instruction;

        - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
        - Related supplies and prescriptions.

    For the purpose of this exclusion:
    - Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
    - Artificial reproduction means the creation of new life other than by the natural means.
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism; and
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during the warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.11.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth; dental implants), except as approved by us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

6. CLAIMS ADMINISTRATION

This section explains how the Plan treats various matters having to do with administering your benefits and/or claims, including situations that may arise in which your health care expenses are the responsibility of a source other than this Plan.

6.1 CLAIMS PAYMENT

The Plan's payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly and pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to the Plan of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber's estate, unless payment to other parties is authorized in writing by you.

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after your claim has been processed. An EOB is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If your claim is denied under the Plan, Providence Health Plan will send an EOB to you with an explanation of the denial within 30 days after your claim is received. If additional time is needed to process your claim for reasons beyond Providence Health Plan's control, you will be sent a notice of delay explaining those reasons within 30 days after your claim if received. The processing will then be completed and you will be sent an EOB within 45 days after your claim is received. If additional information is needed from you to complete the processing of your claim, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you is received, Providence Health Plan will complete the processing of the claim within 30 days.

Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)

- **For Prior Authorization of services that do not involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete their review and provide written notice of its decision to the Member and the provider of their decision. If the information is not received within 15 days, the request will be denied.

- **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.
- **For Formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.

Claims Involving Concurrent Care Decisions. If an ongoing course of treatment for you has been approved under the Plan and it is determined through Concurrent Review procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request a reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. You will then be notified of Providence Health Plan's reconsideration decision within 24 hours after your request is received.

6.1.1 Timely Submission of Claims

The Plan will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if Providence Health Plan receives documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon insurance Division's administrative rule setting standards for prompt payment. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

6.1.2 Right of Recovery

The Plan has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from the Plan under any contract.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB

provision to coordinate other benefits.

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and may reduce the benefits payable so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, Coinsurance and Copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If the Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If the Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If the Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because the Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

6.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
        a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
            i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or

ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
      - The Plan covering the Custodial parent, first;
      - The Plan covering the spouse of the Custodial parent, second;
      - The Plan covering the non-custodial parent, third; and then
      - The Plan covering the Dependent spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:
   i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.
   ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a

Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than would have paid had This Plan been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, benefits may be reduced so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give us any facts Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan.

This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.2.6 Right of Recovery

If the amount of the payments made by This Plan is more than what should have paid under this COB section, This Plan may recover the excess from one or more of the persons This Plan paid or for whom This Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions.

In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B.

When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare.

Counting individuals for the Employer size:

- Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.
- Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member's policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for the Plan to deny any claims for benefits arising from the condition or to terminate the Member's coverage under this Plan as specified in section 9.4. In addition, you or the Member must execute and deliver to the Plan and to other parties any document requested by us which may be appropriate to confirm or secure the

rights and obligations of the Member and the Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the Plan or the Member. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member's heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which the Member or the Member's heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, the Plan will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Plan.

If the Plan makes claim payments on any Member's behalf for any condition for which a third party is responsible, the Plan is entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery.

"Subrogation" means that the Plan may collect directly from the third party to the extent the Plan has paid for third-party liabilities. Because the Plan has paid for the Member's injuries, the Plan, rather than the Member, is entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify the Plan in writing of any terms or conditions offered in settlement and must notify the third party of the Plan's interest in the settlement established by this provision.

To the maximum extent permitted by law, the Plan is subrogated to the Member's rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member's name, and has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

To accomplish this process, the Plan needs detailed information from you or from the Member. A questionnaire will be sent to the Member for this information. It should be completed and returned to Providence Health Plan as soon as possible to minimize any claim review delay. If you or the Member has any questions or concerns regarding the questionnaire, please contact Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason the Plan is not paid directly by the third party, the Plan is entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and the Plan may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by the Plan, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, the Plan is entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. The Plan is entitled to recover up to the full value of the benefits provided by the Plan for the condition, calculated using the Plan's UCR charges for such Services, less the Plan's pro-rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. The Plan is entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Plan, the Member acknowledges the Plan's first priority to this repayment and assigns to us any benefits the Member may have from other sources. The Member must cooperate fully with the Plan and Providence Health Plan in recovering amounts paid by the Plan. If any Member seeks damages against the third party for the condition and retains an attorney or other agent for representation in the matter, that Member agrees to require the Member's attorney or agent to reimburse the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan directly from any settlement or recovery. The Plan may withhold benefits for the Member's condition until a signed copy of this agreement is delivered to the Plan. The agreement must remain in effect and the Plan may withhold payment of benefits if, at any time, the Member's confirmation of the obligations under this section should be revoked. While this document is not necessary for the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that the Plan would otherwise be required to pay under this Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, the Plan is not required to provide coverage for continuing treatment until the Member proves to the Plan's satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. The Plan will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using the Plan's UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. The Plan is entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate you for your medical expenses, regardless of any allocation of proceeds in any settlement document that the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled Family Member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 6.3.2 and 6.3.3 above are modified as provided below.

Before the Plan will be entitled to recover from under a settlement or recovery, you or your enrolled Family Member must first have received full compensation for your injuries. The Plan's entitlement to recover will be payable only from the total amount of the recovery in excess of the amount that fully compensates for the injured person's injuries.

The Plan will not deny or refuse to provide benefits otherwise available to you or your enrolled Family Member because of the possibility that a third party recovery may potentially be available against the person who caused the accident or out of motor vehicle liability or underinsurance coverage.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Your Customer Service representative is available to provide information and assistance. You may call or meet with Providence Health Plan at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;

- Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an internal review. You may request review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or grievance with Providence Health Plan. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or Appeal and Providence Health Plan will consider that information in the review process.
- You can be represented by anyone of your choice at all levels of Appeal.

Request for Claim/Appeal File and Additional Information:

- You can, upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to our decision at any time before, during, or after the appeal process. This includes the specific internal rule, guidelines, protocol, or other similar criterion relied upon to make the Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable.
- You also have the right to request free of charge, at any time, the diagnostic and treatment codes and their meanings that are the subject of your claim or appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.

If you receive the services that were denied in the Adverse Benefit Determination, and if the Adverse Benefit Determination is upheld by internal or external review, you will be financially responsible for any benefits paid by the Plan for such services.

To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. Providence Health plan will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines as noted below.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling Customer Service at 503-574-7500 or 800-878-4445 outside of the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. Providence Health Plan will let you know by phone and letter if your case qualifies for an expedited review. If it does, you will be notified of the decision within 72 hours of receiving your request.

Grievances and Appeals Involving Concurrent Care Decisions: If Providence Health Plan has approved an ongoing course of treatment for you and determines through medical management procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal is of an Adverse Benefit Determination that involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary, you may request an external review by an IRO. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary.**

The Plan pays all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal or requests for External Review to 503-574-8757 or 800-396-4778, or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

If you decline coverage or fail to enroll when you first become eligible, the next earliest time you may enroll is the next occurring Open Enrollment Period.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

Clackamas County will provide an Open Enrollment Period each Plan Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Plan Year for which they enroll.

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine

the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

In instances where an Eligible Family Dependent of a Subscriber qualifies for a "special enrollment period," the Subscriber and the Eligible Family Dependent may:

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) because of other health coverage and you lose that other coverage, the Plan will provide a "special enrollment period" for you and/or your Eligible Family Dependent if:

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and
b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and
c) Such coverage:
    - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
    - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
        1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
        2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized

health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or

3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

Effective Date: Coverage under this Plan will take effect on the first day after the other coverage ended.

8.3.2 New Dependents

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.

The "special enrollment period" shall be a period of 60 days and begins on the later of:

- the date Dependent coverage is made available under this Plan; or
- the date of the marriage, birth, or adoption or placement for adoption.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

If you or your Eligible Family Dependent were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children's Health Insurance Program (CHIP)-sponsored arrangement, the Plan will provide a "special enrollment period" for you and your Family Member(s) if you request enrollment

within 60 days after the date of entitlement.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

For the Subscriber, a leave of absence granted under the federal Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

Termination of Member coverage under this Plan will occur on the earliest of the following dates:

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County of any changes in eligibility including the lack of eligibility of a Family Member. Coverage will not continue beyond the last date of eligibility, regardless of the lack of notice to Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered Dependents the benefits paid as a result of such wrongful activity. Providence Health Plan will provide all affected Plan participants with 30 days' notice before rescinding coverage.

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated because you have engaged in fraudulent, dishonest or threatening behavior, such as:

1. You have filed a false claim with the Plan;
2. You willfully fail to provide information or documentation required to be provided under this Plan or knowingly provide incorrect or incomplete information;
3. You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County reserves the right at any time to terminate or amend in whole or part any of the provisions of the Plan or any of the benefits provided under the Plan. Any such termination or amendment may take effect retroactively or otherwise. In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction and no payments scheduled to be made on or after such effective date will result in any liability to the Plan or Clackamas County.

10. CONTINUATION OF GROUP MEDICAL BENEFITS

If you become ineligible for coverage under this Plan you may, under certain circumstances, continue group coverage. There are specific requirements, time frames and conditions that must be followed in order to be eligible for continuation of group coverage and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that applies to most Employers with 20 or more employees. Some Employers, such as church groups and state agencies, may be exempt from COBRA. The law requires that Employers subject to COBRA offer Employees and/or their Dependents continuation of medical and dental coverage in certain instances where there is a loss of group coverage.

10.1.1 Subscriber's Continuation Coverage

A Subscriber who is covered under this Plan may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

A Spouse or Domestic Partner who is covered under this Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the Subscriber and the Spouse;
- Termination of the domestic partnership; or
- The Subscriber becomes covered under Medicare.

10.1.3 Dependent's Continuation Coverage

A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours;
- The Subscriber's divorce or legal separation;
- Termination of the domestic partnership;
- The Subscriber becomes covered under Medicare; or
- The child ceases to qualify as an Eligible Family Member under this Plan.

A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 Notice Requirements

A Family Member's coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs or a child loses Dependent status under this Plan. **Under COBRA, you or your Family Member has the responsibility to notify Clackamas County if one of these events occurs.** Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When Clackamas County receives notification of one of the above "qualifying" events, you will be notified that you or your Family Member, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, your right to elect continuation coverage under this Plan will be lost.

10.1.5 Type of COBRA Continuation Coverage

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

10.1.6 COBRA Election Rights

A Subscriber or their Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

10.1.7 COBRA Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay the premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.

10.1.8 Length of COBRA Continuation Coverage

18-Month Continuation Period

When coverage ends due to a Subscriber's termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the Subscriber and all covered Family Members will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

29-Month Continuation Period

If a qualified beneficiary is disabled, continuation coverage for that qualified beneficiary and their covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides Clackamas County with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days.

36-Month Continuation Period

If a Spouse, Domestic Partner or Dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The Subscriber's death;
- The Subscriber's eligibility for Medicare;
- Divorce or legal separation;
- Termination of the domestic partnership; or
- A child becomes ineligible for Dependent coverage.

10.1.9 Extension of Continuation Period

If a second qualifying event occurs during the initial 18- or 29-month continuation period (for example, the death of the employee, divorce, or child loses status as an Eligible Family Member under the Plan), coverage for a qualified beneficiary may be extended up to 36 months. However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a Spouse or Dependent child has continuation coverage due to the employee's termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee's Medicare entitlement date.

10.1.10 Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the Pension Benefit Guaranty Corporation (PBGC), to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of sixty-five percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY caller may call toll-free at 866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

10.1.11 When COBRA Continuation Coverage Ends

COBRA Continuation coverage will end automatically for you and your Family Members when any of the following events occurs:

- Clackamas County no longer provides health coverage to any employees;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary (employee, spouse or dependent child) later becomes covered under another health plan;
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. Providence Health Plan wants you to have a positive experience, and are ready to help in any way.

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and In-Network Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS)

The following information applies to Members (participants) who are covered by a plan that is not subject to ERISA.

As a participant in Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, provided you request it in writing and reasonably describe the information.
    - You may obtain copies, subject to paying a reasonable copying charge.
    - You are entitled to know to whom we may have disclosed any such information.
    - You are entitled to correct any errors in the information.

2. Continue group health coverage
    - Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.1.
3. Enforce your rights

    If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

    As more fully described in section 7, the Plan offers a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (IRO) decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2.

    Member's sole right of Appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between the Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A child of an Eligible Employee will be enrolled in the Plan as required by a qualified medical child support order. The procedures and rules regarding this enrollment are described in this section.

12.1 DEFINITIONS

For purposes of this section, the following definitions shall apply:

"Alternate Recipient" means any child of an employee who is recognized under an Order as having a right to enrollment under the Plan with respect to such employee.

An "Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (or through an administrative process established under a state law which has the effect of a court order) which:

- Provides for child support with respect to a child of an employee under the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or
- Enforces a state law relating to medical child support with respect to the Plan.

A "Qualified Medical Child Support Order" or "QMCSO" means an Order:

- Which creates or recognizes the existence of an Alternate Recipient's right to receive, or assigns to an Alternate Recipient the right to receive, benefits for which an employee or beneficiary is eligible under the Plan; and
- With respect to which Clackamas County has determined satisfies the QMSCO standards set forth below.

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section.

"Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County will promptly notify the employee and each Alternate Recipient identified in such Order of the receipt of such Order, and will further furnish them each with a copy of these Procedures. If the Order or any accompanying correspondence identifies a Designated Representative, then copies of the acknowledgment of receipt notice and these Procedures will also then be provided to such Designated Representative.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County will determine whether the Order satisfies the QMCSO standards described below so as to constitute a QMCSO, and shall thereupon notify the employee, each Alternate Recipient, and any Designated Representative of such determination.

An Order will not be deemed to be a QMCSO unless the Order:

(a) Clearly specifies:
    1. The name and last known mailing address (if any) of the employee and of each Alternate Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);
    2. Either a reasonable description of the type of coverage to be provided under the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
    3. The period to which the Order applies.

(b) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

If an Order contains inconsistencies or ambiguities that might pose a risk of future controversy or liability to the Plan, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to Clackamas County will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been voluntary enrolled in the Plan by the employee as a dependent of such employee, including in regard to the payment by the employee for dependent coverage under the Plan. The amount of any required contributions to be made by the Employee for coverage under the Plan will be determined on the basis of the Alternate Recipient being treated as the employee's covered dependent. Any additional required contribution attributable to the coverage of the Alternate Recipient will not be separately charged. Rather, the full amount of the required contribution shall be paid by the employee in accordance with the payroll deduction or other procedures of the Plan as pertaining to the employee.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the employee. Rather, such reimbursement will be paid either to the Alternate Recipient, or to the custodial parent or legal guardian of such Alternate Recipient. However, if the name and address of a State or agency official has been substituted in the Order for that of the Alternate Recipient, then the reimbursement will be paid to such named official.

12.7 STATUS OF ALTERNATE RECIPIENT

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the

Employee under the Plan to which the Order pertains.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County receives an appropriately completed National Medical Support Notice (a "National Notice") issued pursuant to the Child Support Performance and Incentive Act of 1998 in regard to an employee who is a non-custodial parent of a child, and if the National Notice is determined by Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, shall within forty (40) business days after the date of the National Notice notify the State agency issuing the National Notice of the following:

(a) Whether coverage of the child at issue is available under the terms of the Plan, and if so, as to whether such child is covered under the Plan; and
(b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the State or agency official acting on behalf of the child) to effectuate the coverage under the Plan.

Clackamas County shall within such time period also provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the Plan, upon receipt of a National Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as in effect immediately before receipt of such National Notice.

13. GENERAL PROVISIONS

13.1 CONFLICTS OF PROVISIONS

In the event that one or more provisions of this document conflict with one or more provisions of any other plan document, the provisions of this document, as from time to time amended, shall control.

13.2 CONTROLLING STATE LAW

To the extent not preempted by federal laws, the laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the Plan.

13.3 DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, the Plan will pay only under the provision allowing the greater benefit. This may require a recalculation based upon both the amounts already paid and the amounts due to be paid. The Plan has NO liability for benefits other than those this Plan provides.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 GENDER AND NUMBER

Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

13.6 HEADINGS

All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth there under.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2. If ERISA does not apply (see section 11.2), the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND PROVISIONS

The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other employee benefits plan maintained by Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Plan. Neither Clackamas County nor Providence Health Plan will have any liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Providence Health Plan. They will assist you in understanding and complying with the terms of the Plan.

13.10 MEMBERSHIP ID CARD

The membership ID card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

13.11 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is nontransferable.

13.12 NO GUARANTEE OF EMPLOYMENT

Neither the maintenance of the Plan nor any part thereof shall be construed as giving any employee covered hereunder any right to remain in the employ of Clackamas County. No shareholder, director, officer, or employee of Clackamas County in any way guarantees to any Member or beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

13.13 NO RECOURSE FOR ACTS OF PROVIDERS

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. Neither Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 NON-WAIVER

No delay or failure when exercising or enforcing any right under this Plan shall constitute a waiver or relinquishment of that right, and no waiver or any default under this Plan shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Plan shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Providence Health Plan, P.O. Box 3125, Portland, OR 97208.

13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly by an Out-of-Network Provider and you pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to Providence Health Plan of the payment. Payment will be made to the Member, subject to written notice of claim, or, if deceased, to the Member's estate, unless payment to other parties is authorized in writing by you. (See section 6.1.1 regarding timely submission of claims.)

13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. Providence Health Plan, in their discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner considered advisable, to be expended for the person's benefit. PHP's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by Clackamas County and Providence Health Plan.

13.18 PHYSICAL EXAMINATION AND AUTOPSY

When reasonably required for purposes of claim determination, the Plan Sponsor shall have the right to make arrangements for the following examinations, at Plan expense, and to suspend the related claim determination until Providence Health Plan has received and evaluated the results of the examination:

- A physical examination of a Member; or
- An autopsy of a deceased Member, if not forbidden by law.

13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Members, by acceptance of the benefits of this Plan, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or their designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with Providence Health Plan any information relating to any condition for which benefits are claimed under this Plan. Providence Health Plan may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf. If you do not consent to the release of records or to discussions with providers, Providence Health Plan will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

13.20 REQUIRED INFORMATION TO BE FURNISHED

Each Member must furnish to Providence Health Plan such information as they consider necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Member of such true, full and complete information as may be requested.

13.21 RIGHT OF RECOVERY

Providence Health Plan, on behalf of the Plan, has the right, upon demand, to recover payments in excess of the maximum benefits specified in this Plan or payments obtained through fraud, error, or duplicate coverage. If reimbursement is not made to the Plan, Providence Health Plan is authorized by Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 SEVERABILITY

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

13.23 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

- Payment for benefits with respect to a Member under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Member, as required by a State Medicaid Plan;
- The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's enrollment as a Member or beneficiary in the Plan, or in determining or making any payments for benefits of the individual as a Member in the Plan; and
- Payment for benefits under the Plan shall be made to a state in accordance with any state law which provides that the state has acquired the rights with respect to a Member for items or services constituting medical assistance under a State Medicaid Plan.

For purposes of the above, a "State Medicaid Plan" means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

13.24 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees entering into or returning from service in the armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In general, USERRA provides that:

(a) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County to perform services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents) on a self-pay basis. The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 10. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:
    1. The end of the 24-month period beginning on the date on which the employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan sponsored by the Employer with administrative services provided by Providence Health Plan. The funding for the benefits is derived from the funds of the Employer and contributions made by Participants. The Plan is not insured.

This Summary Plan Description constitutes the written instrument under which the Plan is maintained and this document replaces all previous Summary Plan Descriptions. The rights of any person whose employment has terminated, and the rights of such person's covered dependents, will be determined pursuant to the terms of the Plan as in effect on the date such employment terminated, except as may otherwise be specifically provided under the Plan.

14.2 PLAN INFORMATION

Plan Name: Clackamas County Peace Officers Association Personal Option Grandfathered Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The Plan Year begins on January 1st and ends on December 31st

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
800-878-4445

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of the County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer shall be responsible for all fiduciary functions under the Plan except insofar as any such authority or responsibility is assigned by or pursuant to the Plan to another named fiduciary, or is delegated to another fiduciary by the Employer. The Employer has the discretionary authority to determine eligibility for benefits under the Plan and to interpret the terms of the Plan, unless it has delegated that authority as permitted by the Plan. In the event of such delegation, Providence Health Plan's determinations on the meaning of Plan terms may not be overturned unless found by a court to have been arbitrary and capricious. The allocation of administrative duties and the delegation of discretionary authority for the Plan is specified in the Administrative Services Agreement that has been executed by the Employer and Providence Health Plan.

14.7.1 Complete Allocation of Fiduciary Responsibilities

This section is intended to allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each. The performance of such responsibilities will be deemed a several and not a joint assignment. None of such responsibilities nor any other responsibility is intended to be shared by two or more of them unless such sharing will be provided by a specific provision of the Plan. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two will not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction will be deemed to be its sole responsibility, and the responsibility of the one receiving such direction will be to follow it insofar as such direction is on its face proper under the Plan and applicable law.

14.8 ENGAGEMENT OF ADVISORS

The Employer may employ on behalf of the Plan one or more persons to render advice with regard to any responsibility it may have under the Plan. Toward that end, the Employer may appoint, employ and consult with legal counsel, actuaries, accountants, investment consultants, physicians or other advisors (who may be counsel, actuaries, accountants, consultants, physicians or other advisors for the Employer) and may also from time to time utilize the services of employees and agents of the Employer in the discharge of their respective responsibilities.

14.9 INDEMNIFICATION

The Employer will indemnify its employees for any liability or expenses, including attorneys' fees, incurred in the defense of any threatened or pending action, suit or proceeding by reason of their status as a fiduciary with respect to the Plan, to the full extent permitted by law.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

The Employer reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the Plan, or any document forming part of the Plan.

14.10.2 Manner of Action

Any amendment or termination of the Plan or any part of the Plan shall be made by an instrument in writing reflecting that such change has been authorized by the Employer. Any such amendment or termination shall be effective as of the date specified in said instrument, or, if no date is so specified, as of the date of execution or adoption of said instrument. An amendment may be effected by establishment, modification, or termination of the Plan by appropriate action of the Employer. Any such amendment or termination may take effect retroactively or otherwise. An instrument regarding the establishment, modification or termination of the Plan which is executed by the Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 Effect on Benefits

Claims incurred before the effective date of a Plan change or termination will not be affected. Claims incurred after Plan changes will be covered according to the provisions in effect at the time the claim is incurred. Claims incurred after the Plan is terminated will not be covered. You will not be vested in any Plan benefits or have any further rights, subject to applicable law.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan may disclose de-identified summary health information to the Employer for purposes of modifying, amending or terminating this Plan. In addition, Providence Health Plan may disclose protected health information (PHI) to the Employer in accordance with the following provisions of this Plan as established by the Employer:

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) The Employer shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
(i) The Employer shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
(j) The Employer shall provide for adequate separation between the Employer and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of the Employer:
    3. Directors of Human Resources;
    4. Benefit Managers;
    5. Benefit Analysts;
    6. Benefit Specialists; and
    7. Internal Auditors, when performing Health Plan Audits.

Further, the Employer shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for the Employer with regard to this Plan. In addition, the Employer shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

14.11.2 Security

In accordance with the security standards of the Health Insurance Portability and Accountability Act (HIPAA), the Employer shall:

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

The following are definitions of important capitalized terms used in this Summary Plan Description.

Adverse Benefit Determination
See section 7.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in elective same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the documents with that title that are part of your Plan and summarize the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Chemical Dependency
Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products, or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County Peace Officers Association Personal Option Grandfathered Plan

Clackamas County Peace Officers Association Personal Option Grandfathered Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant

See section 4.12.11.

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

Confinement

Confinement means being a resident patient in a Hospital, Skilled Nursing Facility or Qualified Treatment Facility for at least 15 consecutive hours. Successive Confinements are considered to be one Confinement if:

1. Due to the same injury or illness; and
2. Separated by fewer than 30 consecutive days when you are not confined.

Contribution

Contribution means the monetary amount that an Employee is required to contribute as a condition to coverage under the Plan. Specific Contribution amounts are available from your Human Resources office.

Copayment

Copayment means the dollar amount that you are responsible for paying to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary.

Cosmetic Services

Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

1. Listed as a benefit in the Benefit Summary and in section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; and
4. Provided to you while you are a Member and eligible for the Service under this Plan.

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care

Custodial Care means Services that:

1. Do not require the technical skills of a licensed nurse at all times;
2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
3. Are not likely to improve your medical condition.

Such Services will still be considered Custodial Care even if:

1. You are under the care of a physician;
2. The Services are prescribed by a Qualified Practitioner;
3. The Services function to support or maintain your condition; or
4. The Services are being provided by a registered nurse or licensed practical nurse.

Dependent

Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.

Domestic Partner

A Domestic Partner means either of the following:

1. An Oregon Registered Domestic Partner is a person who:
    - Is at least 18 years of age;
    - Has entered into a Domestic Partnership with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
2. A domestic partner who is not an Oregon Registered Domestic Partner is a person at least 18 years of age who:
    - Shares a close personal relationship with a subscriber such that each is responsible for each other's welfare;
    - Is the subscriber's sole domestic partner;
    - Is not married to any person and has not had another domestic partner within the prior six months;
    - Is not related by blood to the subscriber as a first cousin or nearer;
    - Shares with the subscriber the same regular and permanent residence, with the current intention of doing so indefinitely;
    - Is jointly financially responsible with the subscriber for basic living expenses such as food and shelter;
    - Was mentally competent to consent to contract when the domestic partnership began; and
    - Has provided the required employer documentation establishing that a domestic partnership exists.

Note: All provisions of the Plan that apply to a spouse shall apply to a Domestic Partner.

Durable Medical Equipment (DME)

Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;

2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

E-mail Visit

E-mail visit (electronic provider communications) means a consultation through e-mail with an In-Network Provider that is, in the judgment of the In-Network Provider, Medically Necessary and appropriate and involves a significant amount of the In-Network Provider's time. An E-mail visit must relate to the treatment of a covered illness or injury (see also section 4.3.3).

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Plan commences for a Member.

Eligibility Waiting Period

Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee

Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Personal Option Peace Officer Association Employees, COBRA participants and Non-Medicare Eligible Early Retirees.
3. Work Hours: Peace Officers regularly scheduled for at least 20 hours per week. (Not applicable to COBRA and Non-Medicare Eligible Early Retiree.)
4. Eligibility Waiting Period: Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.

9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

The limiting age for each Dependent child is 26 and such children shall become ineligible for coverage on the last day of the month in which their 26th birthday occurs.

A covered Dependent child who attains the limiting age remains eligible if the child is:

a) Developmentally or physically disabled;
b) Incapable of self-sustaining employment prior to the limiting age; and
c) Unmarried.

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under this Plan, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age. Thereafter, Providence Health Plan may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition

See section 4.5.1.

Emergency Medical Screening Exams

See section 4.5.1.

Emergency Services

See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

Endorsement
Endorsement means a document that amends and is part of this Plan.

Essential Health Benefits
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

Exclusion
Exclusion means an item or service that is not a Covered Service under the Plan.

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are :

- Approved by the appropriate governmental regulatory body;
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient provider in the United States;
- Reviewed and supported by national professional medical societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. Providence Health Plan will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon request.

Family Member
Family Member means a Dependent who is properly enrolled in and entitled to Covered

Services under this Plan.

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

Health Benefit Plan
Health Benefit Plan means any Hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple Employer welfare arrangement or other benefit arrangement defined in the federal Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.11.

Hearing Assistance Technology
See section 4.12.11.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Provider
Home Health Provider means a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

Hospital
Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home, Skilled Nursing Facility, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Substance Abuse or Mental Health disorders.

In-Network Provider

In-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

In-Plan

In-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services that are provided by an In-Network Provider.

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

Medically Necessary

Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by Providence Health Plan.

The criteria are based on the following principles:

1. Covered Services are determined to be Medically Necessary if they are health care services or products that a Qualified Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing, preventing, or treating illness (including mental illness), injury, disease or its symptoms, and that are:
    a. In accordance with generally accepted standards of medical practice;
        i. Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Qualified Practitioner specialty society recommendations, the views of Qualified Practitioners practicing in relevant clinical areas, and any other relevant factors;
    b. Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the Member's medical condition;
    c. Not primarily for the convenience of the Member or Qualified Practitioner; and
    d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's illness, injury or disease.

Prudent Clinical Judgment: The "prudent clinical judgment" standard of Medical Necessity ensures that Qualified Practitioners are able to use their expertise and exercise discretion, consistent with good medical care, in determining the Medical Necessity for health care services to be provided to each Member. Covered Services may include, but are not limited to, medical, surgical, diagnostic tests, substance abuse treatment, other health care technologies, supplies, treatments, procedures, drug therapies or devices.

Member
Member means a Subscriber or Eligible Family Dependent, who is properly enrolled in and entitled to Services under this Plan.

Mental Health
Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, during which Eligible Employees are given the opportunity to enroll themselves and their Dependents under the Plan for the upcoming Plan Year, subject to the terms and provisions as found in this Summary Plan Description.

Out-of-Network Provider
Out-of-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital, Skilled Nursing Facility, or Pharmacy that does not have a written agreement with Providence Health Plan to participate as a health care provider for this Plan.

Out-of-Plan
Out-of-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services provided by Out-of-Network Providers.

Out-of-Pocket Maximum
See section 3.13.1.

Outpatient Surgical Facility
Outpatient surgical facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Pharmacy
Participating Pharmacy means pharmacy that has a signed contract with Providence health Plan to provide medications and other Services at special rates. There are four types of Participating Pharmacies:

1. Retail: A Participating Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.

3. Specialty: A Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
4. Mail Order: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Primary Care Provider

Primary Care Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician who agrees to be responsible for the Member's continuing medical care by serving as case manager. Members may also choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

(Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the Provider Directory online or call Customer Service.)

Plan

Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary and any Endorsements, amendments and addendums that accompany this document.

Plan Administrator

Plan Administrator means the "Administrator" or "Plan Administrator" as those terms are defined under ERISA and shall refer to the current or succeeding person, committee, partnership, or other entity designated as such by the terms of the instrument under which the Plan is operated, or by law. Regardless of the terms of the instrument under which the Plan is operated, Providence Health Plan is not the Plan Administrator.

Plan Year

Plan Year means a 12-month time period beginning January 1st and ending December 31st.

Prior Authorization

Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.7.

Prior Authorized determinations are not a guarantee of benefit payment unless:

- A determination that relates to benefit coverage and medical necessity is obtained no more than 30 days prior to the date of the Service; or

- A determination that relates to eligibility is obtained no more than five business days prior to the date of the Service.

Providence Health Plan
Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon and Washington that serves as the claims administrator with respect to this Plan.

Qualified Practitioner
Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery
Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic
Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket, or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified as a "Skilled Nursing Facility" by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Spouse
Spouse means an individual who is legally married to the Subscriber in accordance with the laws of the country or state of celebration.

Subscriber
Subscriber means an employee or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

Summary Plan Description (SPD)
Summary Plan Description (SPD) means the description of the Plan as contained in this document, and includes the provisions of any Benefit Summary, any Endorsements, amendments and addendums that accompany this document, and those policies maintained by Providence Health Plan which clarify any of these documents.

Termination Date of Coverage
Termination Date of Coverage means the date upon which coverage under this Plan ends for a Member. No coverage under the Plan will be provided beyond the Termination Date of Coverage.

Urgent Care
Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.

Urgent Care Covered Services are provided when your medical condition meets the guidelines for Urgent Care that have been established by Providence Health Plan. Covered Services do NOT include Services for the inappropriate use of an Urgent Care facility, such as: services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with In-Network Providers for that Service. UCR charges will never be less than Providence Health Plan's negotiated fees.

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Virtual Visit
Virtual Visit means a visit with an In-Network Provider using secure internet technology:

- Phone and Video Visit:
- Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan

approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife, or licensed direct entry midwife practicing within the applicable lawful scope of practice.

16. NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (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 می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

ADOPTION OF THE SUMMARY PLAN DESCRIPTION AS THE PLAN DOCUMENT

Adoption

On the date shown, below, the Plan Sponsor hereby adopts this Summary Plan Description and the Benefit Summaries, Endorsements and amendments which are incorporated by reference, as the Plan Document of the Clackamas County self-funded Employee Health Benefit Plan, Clackamas County Peace Officers Association Personal Option Grandfathered Plan. This document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for Clackamas County's Eligible Employees and Eligible Family Dependents. Those benefits are described in this Summary Plan Description.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed, effective as of January 1, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); or one of our Sales representatives at 503-574-6300 or 877-245-4077, 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

Clackamas Co POA Personal Option GF SPD
Effective January 01, 2021
Administered by Providence Health Plan

CLACKAMAS COUNTY

Evelyn Minor-Lawrence
Director

DEPARTMENT OF HUMAN RESOURCES

PUBLIC SERVICES BUILDING
2051 Kaen Road | Oregon City, OR 97045

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of Contract with Providence Health & Services – Oregon to provide Medical Screening Services

Purpose/Outcomes	Execution of the contract between Clackamas County, Department of Human Resources (Risk & Safety Division) and Providence Health & Services Oregon
Dollar Amount and Fiscal Impact	Total Contract value not to exceed $500,000. Contractor will bill as time and materials per contracted rates.
Funding Source	Services billed directly to departments
Duration	From Contract execution through October 31, 2025.
Previous Board Action	None
Strategic Plan Alignment	Effectively managing our risks to preserve the assets of the organization from predictable and accidental loss, most closely aligns with the strategic goal of building public trust through good government
Procurement Review	1. Was this item processed through Procurement? ☒ yes ☐ no 2. If no, provide a brief explanation:
Counsel Review	Reviewed Date:11-4-2021 ARN
Contact Person	Eric Machado, Risk Manager, 503-655-8576
Contract #	4811

Background:
The County's existing medical services contract has expired. Clackamas County uses a medical provider to perform medical screening to ensure employees are able to meet pre-employment job classification standards as well as any on-going services that may be required by occupational and health safety rules. Professional services include but are not limited to: job analysis, physical capacity testing, pre-placement exams, drug testing and occupational health monitoring. Clackamas County's Risk and Safety Division has identified Providence as the medical vendor that would best fit the County's current needs.

Procurement Process:
This project was advertised in accordance with ORS and LCRB Rules on August 26, 2021. Proposals were opened on September 27, 2021. The County received two (2) proposals, from: Occupational health Centers, dba Concertra Health Centers, and Providence Health and Services – Oregon. The evaluation committed consisted of six (6) County employees from various departments that would use this service. . The evaluation committee recommended that Providence Health and Services - Oregon be awarded the Contract. A notice of intent to award was published on October 19, 2021 and no protests were received.

Recommendation:
Staff respectfully recommends that the board approve and execute the Contract with Providence Health and Services – Oregon for Medical Screening Services.
Sincerely,

Evelyn Minor-Lawrence, IPMA-CP

Digitally signed by Evelyn Minor-Lawrence, IPMA-CP
Date: 2021.11.09 12:56:40 -08'00'

Evelyn Minor-Lawrence, Director

Placed on the BCC Agenda _____ by Procurement and Contract Services

CLACKAMAS COUNTY
PERSONAL SERVICES CONTRACT
Contract #4811

This Personal Services Contract (this "Contract") is entered into between **Providence Health & Services - Oregon** ("Contractor"), and Clackamas County, a political subdivision of the State of Oregon ("County").

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 October 31, 2025. This Contract may be renewed for one (1) additional one-year term at the written approval of both parties.

2. **Scope of Work.** Contractor shall provide on-call medical screening services ("Work"), further described in RFP 2021-65 Medical Screening Services, attached hereto as **Exhibit A** and incorporated by reference.

   This Contract is on an "on-call" or "as-needed basis" for Work.

   When the County wishes Contractor to perform the Work, the County will submit an official County Task Order form (found at: https://www.clackamas.us/finance/terms.html) detailing the Scope of Work, the entity on whose behalf the Work will be performed, and the total compensation, pursuant to the fee schedule set forth in this Contract. Contractor may not perform Work until the County Task Order form has been executed by the parties. In the event a project authorized under the County Task Order extends beyond the expiration of this Contract, the County Task Order shall remain in effect under the terms of this Contract until the completion or expiration of the authorized task.

   No Task Order shall modify or amend the terms and conditions of this Contract.

   Contractor agrees to perform the Work on behalf of the County and the following entities: Water Environment Services, North Clackamas Parks and Recreation District, the Development Agency of Clackamas County, the Housing Authority of Clackamas County, and any special district or urban renewal agency that follows the County's Local Contract Review Board rules and is approved by the County, in writing, to receive the Work under this Contract.

3. **Consideration.** In consideration for Contractor performing the Work, the County agrees to pay Contractor, from available and authorized funds, a sum not to exceed $100,000.00 per Contract year, for a total amount not to exceed **$500,000.00** over the life of this Contract, including the optional one-year renewal. Consideration rates are on a time and materials basis in accordance with the rates and costs specified in **Exhibit C**, Contractors Proposal. If any interim payments to Contractor are made, such payments shall be made only in accordance with the schedule and requirements in Exhibit A and Exhibit B.

4. **Invoices and Payments.** Unless otherwise specified, Contractor shall submit monthly invoices for Work performed. Invoices shall describe all Work performed with particularity, by whom it was performed, and shall itemize and explain all expenses for which reimbursement is claimed. The invoices shall include the total amount billed to date by Contractor prior to the current invoice. If Contractor fails to present invoices in proper form within sixty (60) calendar days after the end of the month in which the services were rendered, Contractor waives any rights to present such invoice thereafter and to receive payment therefor. Payments shall be made in accordance with ORS 293.462 to Contractor following the County's review and approval of invoices submitted by Contractor. Contractor shall not submit invoices for, and the County will not be obligated to pay, any amount in excess of the maximum compensation amount set forth above. If this maximum compensation

amount is increased by amendment of this Contract, the amendment must be fully effective before Contractor performs Work subject to the amendment.

Invoices shall be provided to the County Representative as noted on each individual Task Order.

5. **Travel and Other Expense.** Authorized: ☐ Yes ☒ No
If travel expense reimbursement is authorized in this Contract, such expense shall only be reimbursed at the rates in the County Contractor Travel Reimbursement Policy, hereby incorporated by reference and found at: https://www.clackamas.us/finance/terms.html.Travel expense reimbursement is not in excess of the not to exceed consideration.

6. **Contract Documents.** This Contract consists of the following documents, which are listed in descending order of precedence and are attached and incorporated by reference, this Contract, Exhibit A, Exhibit B, Exhibit C, and Exhibit D.

7. **Contractor and County Contacts.**

Contractor Administrator: Aimee Tinkle Phone: 971-369-0823 Email: aimee.tinkle@providence.org	**County Administrator:** Eric Machado Phone: 503-655-8576 Email: emachado@clackamas.us

Payment information will be reported to the Internal Revenue Service ("IRS") under the name and taxpayer ID number submitted. (See I.R.S. 1099 for additional instructions regarding taxpayer ID numbers.) Information not matching IRS records will subject Contractor payments to backup withholding.

ARTICLE II.

1. **ACCESS TO RECORDS.** Contractor shall maintain books, records, documents, and other evidence, in accordance with generally accepted accounting procedures and practices, sufficient to reflect properly all costs of whatever nature claimed to have been incurred and anticipated to be incurred in the performance of this Contract. County and their duly authorized representatives shall have access to the books, documents, papers, and records of Contractor, which are directly pertinent to this Contract for the purpose of making audit, examination, excerpts, and transcripts. Contractor shall maintain such books and records for a minimum of six (6) years, or such longer period as may be required by applicable law, following final payment and termination of this Contract, or until the conclusion of any audit, controversy or litigation arising out of or related to this Contract, whichever date is later.

2. **AVAILABILITY OF FUTURE FUNDS.** Any continuation or extension of this Contract after the end of the fiscal period in which it is written is contingent on a new appropriation for each succeeding fiscal period sufficient to continue to make payments under this Contract, as determined by the County in its sole administrative discretion.

3. **CAPTIONS.** The captions or headings in this Contract are for convenience only and in no way define, limit, or describe the scope or intent of any provisions of this Contract.

4. **COMPLIANCE WITH APPLICABLE LAW.** Contractor shall comply with all applicable federal, state and local laws, regulations, executive orders, and ordinances, as such may be amended from time to time.

5. **COUNTERPARTS.** This Contract may be executed in several counterparts (electronic or otherwise), each of which shall be an original, all of which shall constitute the same instrument.

6. **GOVERNING LAW.** This Contract, and all rights, obligations, and disputes arising out of it, shall be governed and construed in accordance with the laws of the State of Oregon and the ordinances of Clackamas County without regard to principles of conflicts of law. Any claim, action, or suit between County and Contractor that arises out of or relates to the performance of this Contract shall be brought and conducted solely and exclusively within the Circuit Court for Clackamas County, for the State of Oregon. Provided, however, that if any such claim, action, or suit may be brought in a federal forum, it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the County of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. Contractor, by execution of this Contract, hereby consents to the personal jurisdiction of the courts referenced in this section.

7. **RESPONSIBILITY FOR DAMAGES; INDEMNITY.** Contractor shall be responsible for all damage to property, injury to persons, and loss, expense, inconvenience, and delay which may be caused by, or result from, the conduct of Work, or from any act, omission, or neglect of Contractor, its subcontractors, agents, or employees. The Contractor agrees to indemnify, hold harmless and defend the County, and its officers, elected officials, agents and employees from and against all claims and actions, and all expenses incidental to the investigation and defense thereof, arising out of or based upon damage or injuries to persons or property caused by the errors, omissions, fault or negligence of the Contractor or the Contractor's employees, subcontractors, or agents. However, neither Contractor nor any attorney engaged by Contractor shall defend the claim in the name of County or any department of County, nor purport to act as legal representative of County or any of its departments, without first receiving from the Clackamas County Counsel's Office authority to act as legal counsel for County, nor shall Contractor settle any claim on behalf of County without the approval of the Clackamas County Counsel's Office. County may, at its election and expense, assume its own defense and settlement.

8. **INDEPENDENT CONTRACTOR STATUS.** The service(s) to be rendered under this Contract are those of an independent contractor. Although the County reserves the right to determine (and modify) the delivery schedule for the Work to be performed and to evaluate the quality of the completed performance, County cannot and will not control the means or manner of Contractor's performance. Contractor is responsible for determining the appropriate means and manner of performing the Work. Contractor is not to be considered an agent or employee of County for any purpose, including, but not limited to: (A) The Contractor will be solely responsible for payment of any Federal or State taxes required as a result of this Contract; and (B) This Contract is not intended to entitle the Contractor to any benefits generally granted to County employees, including, but not limited to, vacation, holiday and sick leave, other leaves with pay, tenure, medical and dental coverage, life and disability insurance, overtime, Social Security, Workers' Compensation, unemployment compensation, or retirement benefits.

9. **INSURANCE.** Contractor shall secure at its own expense and keep in effect during the term of the performance under this Contract the insurance required and minimum coverage indicated below. The insurance requirement outlined below do not in any way limit the amount of scope of liability of Contractor under this Contract. Contractor shall provide proof of said insurance and name the County as an additional insured 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 statutory workers' compensation requirements in ORS 656.017, unless exempt under ORS 656.027 or 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 claim, with an annual aggregate limit of $2,000,000 for damages caused by error, omission or negligent acts.
☒ Required –Medical Professional Liability: combined single limit, or the equivalent, of not less than $1,000,000 per claim, with an annual aggregate limit of $3,000,000 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 accident for Bodily Injury and Property Damage.
☐ Required – Abuse & Molestation endorsement with limits not less than $1,000,000 per occurrence if not included in the Commercial General Liability policy.
☒ Required – Cyber Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence for network security (including data breach), privacy, interruption of business, media liability, and errors and omissions.

The policy(s) shall be primary insurance as respects to the County. Any insurance or self-insurance maintained by the County shall be excess and shall not contribute to it. Any obligation that County 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 20 neither party shall be liable for (i) any indirect, incidental, consequential or special damages under this Contract or (ii) any damages of any sort arising solely from the termination of this Contact in accordance with its terms.

11. **NOTICES.** Except as otherwise provided in this Contract, any required notices between the parties shall be given in writing by personal delivery, email, or mailing the same, to the Contract Administrators identified in Article 1, Section 6. If notice is sent to County, a copy shall also be sent to: Clackamas County Procurement, 2051 Kaen Road, Oregon City, OR 97045, or procurement@clackamas.us. Any communication or notice so addressed and mailed shall be deemed to be given five (5) days after mailing, and immediately upon personal delivery, or within 2 hours after the email is sent during County's normal business hours (Monday – Thursday, 7:00 a.m. to 6:00 p.m.) (as recorded on the device from which the sender sent the email), unless the sender receives an automated message or other indication that the email has not been delivered.

12. **OWNERSHIP OF WORK PRODUCT.** All work product of Contractor that results from this Contract (the "Work Product") is the exclusive property of County. County and Contractor intend that such Work Product be deemed "work made for hire" of which County shall be deemed the author. If for any reason the Work Product is not deemed "work made for hire," Contractor hereby irrevocably assigns to County all of its right, title, and interest in and to any and all of the Work Product, whether arising from copyright, patent, trademark or trade secret, or any other state or federal intellectual property law or doctrine. Contractor shall execute such further documents and instruments as County may reasonably request in order to fully vest such rights in County. Contractor forever waives any and all rights relating to the Work Product, including without limitation, any and all rights arising under 17 USC § 106A or any other rights of identification of authorship or rights of approval, restriction or limitation on use or subsequent modifications. Notwithstanding the above, County shall have no rights in any pre-existing Contractor intellectual

property provided to County by Contractor in the performance of this Contract except to copy, use and re-use any such Contractor intellectual property for County use only.

13. **REPRESENTATIONS AND WARRANTIES.** Contractor represents and warrants to County that (A) Contractor has the power and authority to enter into and perform this Contract; (B) this Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms; (C) Contractor shall at all times during the term of this Contract, be qualified, professionally competent, and duly licensed to perform the Work; (D) Contractor is an independent contractor as defined in ORS 670.600; and (E) the Work under this Contract shall be performed in a good and workmanlike manner and in accordance with the highest professional standards. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

14. **SURVIVAL.** All rights and obligations shall cease upon termination or expiration of this Contract, except for the rights and obligations set forth in Article II, Sections 1, 6, 7, 10, 12, 13, 14, 15, 17, 20, 21, 25, 27, 28, and 31 and all other rights and obligations which by their context are intended to survive. However, such expiration shall not extinguish or prejudice the County's right to enforce this Contract with respect to: (a) any breach of a Contractor warranty; or (b) any default or defect in Contractor performance that has not been cured.

15. **SEVERABILITY.** If any term or provision of this Contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the Contract did not contain the particular term or provision held to be invalid.

16. **SUBCONTRACTS AND ASSIGNMENTS.** Contractor shall not enter into any subcontracts for any of the Work required by this Contract, or assign or transfer any of its interest in this Contract by operation of law or otherwise, without obtaining prior written approval from the County, which shall be granted or denied in the County's sole discretion. In addition to any provisions the County may require, Contractor shall include in any permitted subcontract under this Contract a requirement that the subcontractor be bound by this Article II, Sections 1, 7, 8, 13, 16 and 27 as if the subcontractor were the Contractor. County's consent to any subcontract shall not relieve Contractor of any of its duties or obligations under this Contract.

17. **SUCCESSORS IN INTEREST.** The provisions of this Contract shall be binding upon and shall inure to the benefit of the parties hereto, and their respective authorized successors and assigns.

18. **TAX COMPLIANCE CERTIFICATION.** The Contractor shall comply with all federal, state and local laws, regulation, executive orders and ordinances applicable to this Contract. Contractor represents and warrants that it has complied, and will continue to comply throughout the duration of this Contract and any extensions, with all tax laws of this state or any political subdivision of this state, including but not limited to ORS 305.620 and ORS chapters 316, 317, and 318. Any violation of this section shall constitute a material breach of this Contract and shall entitle County to terminate this Contract, to pursue and recover any and all damages that arise from the breach and the termination of this Contract, and to pursue any or all of the remedies available under this Contract or applicable law.

19. **TERMINATIONS.** This Contract may be terminated for the following reasons: (A) by mutual agreement of the parties; (B) by either party for convenience upon thirty (30) days written notice to the non-terminating party; (C) by County at any time the County fails to receive funding, appropriations, or other expenditure authority as solely determined by the County; or (D) if Contractor breaches any Contract provision or is declared insolvent, County may terminate after thirty (30) days written notice with an opportunity to cure.

Upon receipt of written notice of termination from the County, Contractor shall immediately stop performance of the Work. Upon termination of this Contract, Contractor shall deliver to County all documents, Work Product, information, works-in-progress and other property that are or would be deliverables had the Contract Work been completed. Upon County's request, Contractor shall surrender to anyone County designates, all documents, research, objects or other tangible things needed to complete the Work.

20. **REMEDIES.** If terminated by the County due to a breach by the Contractor, then the County shall have any remedy available to it in law or equity. If this Contract is terminated for any other reason, Contractor's sole remedy is payment for the goods and services delivered and accepted by the County, less any setoff to which the County is entitled.

21. **NO THIRD PARTY BENEFICIARIES.** County and Contractor are the only parties to this Contract and are the only parties entitled to enforce its terms. Nothing in this Contract gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Contract.

22. **TIME IS OF THE ESSENCE.** Contractor agrees that time is of the essence in the performance this Contract.

23. **FOREIGN CONTRACTOR.** If the Contractor is not domiciled in or registered to do business in the State of Oregon, Contractor shall promptly provide to the Oregon Department of Revenue and the Secretary of State, Corporate Division, all information required by those agencies relative to this Contract. The Contractor shall demonstrate its legal capacity to perform these services in the State of Oregon prior to entering into this Contract.

24. **FORCE MAJEURE.** Neither County nor Contractor shall be held responsible for delay or default caused by events outside the County or Contractor's reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war. However, Contractor shall make all reasonable efforts to remove or eliminate such a cause of delay or default and shall upon the cessation of the cause, diligently pursue performance of its obligations under this Contract.

25. **WAIVER.** The failure of County to enforce any provision of this Contract shall not constitute a waiver by County of that or any other provision.

26. **PUBLIC CONTRACTING REQUIREMENTS.** Pursuant to the public contracting requirements contained in Oregon Revised Statutes ("ORS") Chapter 279B.220 through 279B.235, Contractor shall:
    a. Make payments promptly, as due, to all persons supplying to Contractor labor or materials for the prosecution of the work provided for in the Contract.
    b. Pay all contributions or amounts due the Industrial Accident Fund from such Contractor or subcontractor incurred in the performance of the Contract.
    c. Not permit any lien or claim to be filed or prosecuted against County on account of any labor or material furnished.
    d. Pay the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.
    e. As applicable, the Contractor shall pay employees for work in accordance with ORS 279B.235, which is incorporated herein by this reference. The Contractor shall comply with the prohibitions set forth in ORS 652.220, compliance of which is a material element of this Contract, and failure to comply is a breach entitling County to terminate this Contract for cause.

f. If the Work involves lawn and landscape maintenance, Contractor shall salvage, recycle, compost, or mulch yard waste material at an approved site, if feasible and cost effective.

27. NO ATTORNEY FEES. In the event any arbitration, action or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Contract, each party shall be responsible for its own attorneys' fees and expenses.

28. CONFIDENTIALITY. Contractor acknowledges that it and its employees and agents may, in the course of performing their obligations under this Contract, be exposed to or acquire information that the County desires or is required to maintain as confidential. Any and all information of any form obtained by Contractor or its employees or agents in the performance of this Contract, including but not limited to Personal Information (as "Personal Information" is defined in ORS 646A.602(11), shall be deemed to be confidential information of the County ("Confidential Information"). Any reports or other documents or items (including software) which result from the use of the Confidential Information by Contractor shall be treated with respect to confidentiality in the same manner as the Confidential Information.

Contractor agrees to hold Confidential Information in strict confidence, using at least the same degree of care that Contractor uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give or disclose Confidential Information to third parties or use Confidential Information for any purposes whatsoever (other than in the performance of this Contract), and to advise each of its employees and agents of their obligations to keep Confidential Information confidential.

Contractor agrees that, except as directed by the County, Contractor will not at any time during or after the term of this Contract, disclose, directly or indirectly, any Confidential Information to any person, and that upon termination or expiration of this Contract or the County's request, Contractor will turn over to the County all documents, papers, records and other materials in Contractor's possession which embody Confidential Information. Contractor acknowledges that breach of this Contract, including disclosure of any Confidential Information, or disclosure of other information that, at law or in good conscience or equity, ought to remain confidential, will give rise to irreparable injury to the County that cannot adequately be compensated in damages. Accordingly, the County may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies that may be available. Contractor acknowledges and agrees that the covenants contained herein are necessary for the protection of the legitimate business interests of the County and are reasonable in scope and content.

Contractor agrees to comply with all reasonable requests by the County to ensure the confidentiality and nondisclosure of the Confidential Information, including if requested and without limitation: (a) obtaining nondisclosure agreements, in a form approved by the County, from each of Contractor's employees and agents who are performing services, and providing copies of such agreements to the County; and (b) performing criminal background checks on each of Contractor's employees and agents who are performing services, and providing a copy of the results to the County.

Contractor shall report, either orally or in writing, to the County any use or disclosure of Confidential Information not authorized by this Contract or in writing by the County, including any reasonable belief that an unauthorized individual has accessed Confidential Information. Contractor shall make the report to the County immediately upon discovery of the unauthorized disclosure, but in no event more than two (2) business days after Contractor reasonably believes there has been such unauthorized use or disclosure. Contractor's report shall identify: (i) the nature of the unauthorized use or disclosure, (ii) the Confidential Information used or disclosed, (iii) who made the unauthorized use or received the unauthorized disclosure, (iv) what Contractor has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure, and (v) what corrective action Contractor has

taken or shall take to prevent future similar unauthorized use or disclosure. Contractor shall provide such other information, including a written report, as reasonably requested by the County.

Notwithstanding any other provision in this Contract, Contractor will be responsible for all damages, fines and corrective action (including credit monitoring services) arising from disclosure of such Confidential Information caused by a breach of its data security or the confidentiality provisions hereunder.

The provisions in this Section shall operate in addition to, and not as limitation of, the confidentiality and similar requirements set forth in the rest of the Contract, as it may otherwise be amended. Contractor's obligations under this Contract shall survive the expiration or termination of the Contract, as amended, and shall be perpetual.

29. **COOPERATIVE CONTRACTING.** Pursuant to ORS 279A.200 to 279A.225, other public agencies may use this Contract resulting from a competitive procurement process unless the Contractor expressly noted in their proposal/quote that the prices and services are available to the County only. The condition of such use by other agencies is that any such agency must make and pursue contact, purchase order, delivery arrangements, and all contractual remedies directly with Contractor; the County accepts no responsibility for performance by either the Contractor or such other agency using this Contract. With such condition, the County consents to such use by any other public agency.

30. **FEDERAL CONTRACTING REQUIREMENTS**. County intends that all or a portion of the consideration paid to Contractor is eligible for reimbursement by one or more federal agencies including, but not limited to, the Federal Emergency Management Agency. This Contract is subject to the additional terms and conditions, required by federal law for a federal award, set in **Exhibit B**, attached hereto and incorporated by this reference herein. All terms and conditions required under applicable federal law for a federal reward including, but no limited to, 2 C.F.R. § 200.326 and 2 C.F.R. § Pt. 200, App. II, are hereby incorporated by this reference herein.

    Contractor shall, as soon as commercially practicable, register itself with the federal System for Award Management (SAM). Information regarding registration with SAM may be found at https://www.sam.gov.

31. **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 FOLLOWS

By their signatures below, the parties to this Contract agree to the terms, conditions, and content expressed herein.

Providence Health & Services - Oregon

Aimee L Tinkle Digitally signed by Aimee L Tinkle Date: 2021.11.04 09:59:21 -07'00' 11/04/2021

Authorized Signature Date

Aimee Tinkle, Sr Manager

Name / Title (Printed)

037230-12 DNP / Oregon

Oregon Business Registry #

Clackamas County

Chair

Recording Secretary Date

Approved as to Form:

Andrew Naylor Digitally signed by Andrew Naylor Date: 2021.11.04 13:15:24 -07'00'

County Counsel Date

EXHIBIT A
RFP 2021-65 MEDICAL SCREENING SERVICES
ISSUED: August 26, 2021

REQUEST FOR PROPOSALS #2021-65

FOR

MEDICAL SCREENING SERVICES

BOARD OF COUNTY COMMISSIONERS
TOOTIE SMITH, Chair
SONYA FISCHER, Commissioner
PAUL SAVAS, Commissioner
MARK SHULL, Commissioner
MARTHA SCHRADER, Commissioner

Gary Schmidt
County Administrator

Kim Randall
Contract Analyst

PROPOSAL CLOSING DATE, TIME AND LOCATION

DATE: **September 27, 2021**

TIME: **2:00 PM, Pacific Time**

PLACE: **Procurement@clackamas.us**

SCHEDULE

Request for Proposals Issued…….....August 26, 2021

Protest of Specifications Deadline.....September 2, 2021, 5:00 PM, Pacific Time

Deadline to Submit Clarifying Questions.....September 16, 2021, 5:00 PM, Pacific Time

Request for Proposals Closing Date and Time…….....September 27, 2021, 2:00 PM, Pacific Time

Deadline to Submit Protest of Award.....Seven (7) days from the Intent to Award

Anticipated Contract Start Date…….....November 2021

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SECTION 1
NOTICE OF REQUEST FOR PROPOSALS

Notice is hereby given that Clackamas County through its Board of County Commissioners will receive sealed Proposals per specifications until **2:00 PM, September 27, 2021** ("Closing"), to provide Medical Screening Services**.** No Proposals will be received or considered after that time.

RFP Documents can be downloaded from the state of Oregon procurement website ("OregonBuys") at the following address https://oregonbuys.gov/bso/view/login/login.xhtml, Document No. S-C01010-000000605.

Prospective Proposers will need to sign in to download the information and that information will be accumulated for a Plan Holder's List. Prospective Proposers are responsible for obtaining any Addenda, clarifying questions, and Notices of Award from OregonBuys. Sealed Proposals are to be emailed to Clackamas County Procurement Services at procurement@clackamas.us.

Contact Information
Procurement Process and Technical Questions: Kim Randall, 503-742-5443 or email preferred at krandall@clackamas.us

The Board of County Commissioners reserves the right to reject any and all Proposals not in compliance with all prescribed public bidding procedures and requirements, and may reject for good cause any and all Proposals upon the finding that it is in the public interest to do so and to waive any and all informalities in the public interest. In the award of the contract, the Board of County Commissioners will consider the element of time, will accept the Proposal or Proposals which in their estimation will best serve the interests of Clackamas County and will reserve the right to award the contract to the contractor whose Proposal shall be best for the public good.

Clackamas County encourages proposals from Minority, Women, Veteran and Emerging Small Businesses.

SECTION 2
INSTRUCTIONS TO PROPOSERS

Clackamas County ("County") reserves the right to reject any and all Proposals received as a result of this RFP. County Local Contract Review Board Rules ("LCRB") govern the procurement process for the County.

2.1 Modification or Withdrawal of Proposal: Any Proposal may be modified or withdrawn at any time prior to the Closing deadline, provided that a written request is received by the County Procurement Division Director, prior to the Closing. The withdrawal of a Proposal will not prejudice the right of a Proposer to submit a new Proposal.

2.2 Requests for Clarification and Requests for Change: Proposers may submit questions regarding the specifications of the RFP. Questions must be received in writing on or before 5:00 p.m. (Pacific Time), on the date indicated in the Schedule, at the Procurement Division address as listed in Section 1 of this RFP. Requests for changes must include the reason for the change and any proposed changes to the requirements. The purpose of this requirement is to permit County to correct, prior to the opening of Proposals, RFP terms or technical requirements that may be unlawful, improvident or which unjustifiably restrict competition. County will consider all requested changes and, if appropriate, amend the RFP. No oral or written instructions or information concerning this RFP from County managers, employees or agents to prospective Proposers shall bind County unless included in an Addendum to the RFP.

2.3 Protests of the RFP/Specifications: Protests must be in accordance with LCRB C-047-0730. Protests of Specifications must be received in writing on or before 5:00 p.m. (Pacific Time), on the date indicated in the Schedule, or within three (3) business days of issuance of any addendum, at the Procurement Division address listed in Section 1 of this RFP. Protests may not be faxed. Protests of the RFP specifications must include the reason for the protest and any proposed changes to the requirements.

2.4 Addenda: If any part of this RFP is changed, an addendum will be provided to Proposers that have provided an address to the Procurement Division for this procurement. It shall be Proposers responsibility to regularly check OregonBuys for any notices, published addenda, or response to clarifying questions.

2.5 Submission of Proposals: Proposals must be submitted in accordance with Section 5. All Proposals shall be legibly written in ink or typed and comply in all regards with the requirements of this RFP. Proposals that include orders or qualifications may be rejected as irregular. All Proposals must include a signature that affirms the Proposer's intent to be bound by the Proposal (may be on cover letter, on the Proposal, or the Proposal Certification Form) shall be signed. If a Proposal is submitted by a firm or partnership, the name and address of the firm or partnership shall be shown, together with the names and addresses of the members. If the Proposal is submitted by a corporation, it shall be signed in the name of such corporation by an official who is authorized to bind the contractor. The Proposals will be considered by the County to be submitted in confidence and are not subject to public disclosure until the notice of intent to award has been issued.

No late Proposals will be accepted. Proposals submitted after the Closing will be considered late and will be returned unopened. Proposals may not be submitted by telephone or fax.

2.6 Post-Selection Review and Protest of Award: County will name the apparent successful Proposer in a Notice of Intent to Award published on OregonBuys. Identification of the apparent successful Proposer is procedural only and creates no right of the named Proposer to award of the contract. Competing Proposers shall be given seven (7) calendar days from the date on the Notice of Intent to Award to review the file at the Procurement Division office and file a written protest of award, pursuant to LCRB C-047-0740. Any award protest must be in writing and must be delivered by hand-delivery or mail to the address for the Procurement Division as listed in Section 1 of this RFP.

Only actual Proposers may protest if they believe they have been adversely affected because the Proposer would be eligible to be awarded the contract in the event the protest is successful. The basis of the written protest must

be in accordance with ORS 279B.410 and shall specify the grounds upon which the protest is based. In order to be an adversely affected Proposer with a right to submit a written protest, a Proposer must be next in line for award, i.e. the protester must claim that all higher rated Proposers are ineligible for award because they are non-responsive or non-responsible.

County will consider any protests received and:

a. reject all protests and proceed with final evaluation of, and any allowed contract language negotiation with, the apparent successful Proposer and, pending the satisfactory outcome of this final evaluation and negotiation, enter into a contract with the named Proposer; OR
b. sustain a meritorious protest(s) and reject the apparent successful Proposer as nonresponsive, if such Proposer is unable to demonstrate that its Proposal complied with all material requirements of the solicitation and Oregon public procurement law; thereafter, County may name a new apparent successful Proposer; OR
c. reject all Proposals and cancel the procurement.

2.7 Acceptance of Contractual Requirements: Failure of the selected Proposer to execute a contract and deliver required insurance certificates within ten (10) calendar days after notification of an award may result in cancellation of the award. This time period may be extended at the option of County.

2.8 Public Records: Proposals are deemed confidential until the "Notice of Intent to Award" letter is issued. This RFP and one copy of each original Proposal received in response to it, together with copies of all documents pertaining to the award of a contract, will be kept and made a part of a file or record which will be open to public inspection. If a Proposal contains any information that is considered a **TRADE SECRET** under ORS 192.345(2), **SUCH INFORMATION MUST BE LISTED ON A SEPARATE SHEET CAPABLE OF SEPARATION FROM THE REMAINING PROPOSAL AND MUST BE CLEARLY MARKED WITH THE FOLLOWING LEGEND:**

"This information constitutes a trade secret under ORS 192.345(2), and shall not be disclosed except in accordance with the Oregon Public Records Law, ORS Chapter 192."

The Oregon Public Records Law exempts from disclosure only bona fide trade secrets, and the exemption from disclosure applies only "unless the public interest requires disclosure in the particular instance" (ORS 192.345). Therefore, non-disclosure of documents, or any portion of a document submitted as part of a Proposal, may depend upon official or judicial determinations made pursuant to the Public Records Law.

2.9 Investigation of References: County reserves the right to investigate all references in addition to those supplied references and investigate past performance of any Proposer with respect to its successful performance of similar services, its compliance with specifications and contractual obligations, its completion or delivery of a project on schedule, its lawful payment of subcontractors and workers, and any other factor relevant to this RFP. County may postpone the award or the execution of the contract after the announcement of the apparent successful Proposer in order to complete its investigation.

2.10 RFP Proposal Preparation Costs and Other Costs: Proposer costs of developing the Proposal, cost of attendance at an interview (if requested by County), or any other costs are entirely the responsibility of the Proposer, and will not be reimbursed in any manner by County.

2.11 Clarification and Clarity: County reserves the right to seek clarification of each Proposal, or to make an award without further discussion of Proposals received. Therefore, it is important that each Proposal be submitted initially in the most complete, clear, and favorable manner possible.

2.12 Right to Reject Proposals: County reserves the right to reject any or all Proposals or to withdraw any item from the award, if such rejection or withdrawal would be in the public interest, as determined by County.

2.13 Cancellation: County reserves the right to cancel or postpone this RFP at any time or to award no contract.

2.14 Proposal Terms: All Proposals, including any price quotations, will be valid and firm through a period of one hundred and eighty (180) calendar days following the Closing date. County may require an extension of this firm offer period. Proposers will be required to agree to the longer time frame in order to be further considered in the procurement process.

2.15 Oral Presentations: At County's sole option, Proposers may be required to give an oral presentation of their Proposals to County, a process which would provide an opportunity for the Proposer to clarify or elaborate on the Proposal but will in no material way change Proposer's original Proposal. If the evaluating committee requests presentations, the Procurement Division will schedule the time and location for said presentation. Any costs of participating in such presentations will be borne solely by Proposer and will not be reimbursed by County. **Note:** Oral presentations are at the discretion of the evaluating committee and may not be conducted; therefore, **written Proposals should be complete.**

2.16 Usage: It is the intention of County to utilize the services of the successful Proposer(s) to provide services as outlined in the below Scope of Work.

2.17 Review for Responsiveness: Upon receipt of all Proposals, the Procurement Division or designee will determine the responsiveness of all Proposals before submitting them to the evaluation committee. If a Proposal is incomplete or non-responsive in significant part or in whole, it will be rejected and will not be submitted to the evaluation committee. County reserves the right to determine if an inadvertent error is solely clerical or is a minor informality which may be waived, and then to determine if an error is grounds for disqualifying a Proposal. The Proposer's contact person identified on the Proposal will be notified, identifying the reason(s) the Proposal is non-responsive. One copy of the Proposal will be archived and all others discarded.

2.18 RFP Incorporated into Contract: This RFP will become part of the Contract between County and the selected contractor(s). The contractor(s) will be bound to perform according to the terms of this RFP, their Proposal(s), and the terms of the Sample Contract.

2.19 Communication Blackout Period: Except as called for in this RFP, Proposers may not communicate with members of the Evaluation Committee or other County employees or representatives about the RFP during the procurement process until the apparent successful Proposer is selected, and all protests, if any, have been resolved. Communication in violation of this restriction may result in rejection of a Proposer.

2.20 Prohibition on Commissions and Subcontractors: County will contract directly with persons/entities capable of performing the requirements of this RFP. Contractors must be represented directly. Participation by brokers or commissioned agents will not be allowed during the Proposal process. Contractor shall not use subcontractors to perform the Work unless specifically pre-authorized in writing to do so by the County. Contractor represents that any employees assigned to perform the Work, and any authorized subcontractors performing the Work, are fully qualified to perform the tasks assigned to them, and shall perform the Work in a competent and professional manner. Contractor shall not be permitted to add on any fee or charge for subcontractor Work. Contractor shall provide, if requested, any documents relating to subcontractor's qualifications to perform required Work.

2.21 Ownership of Proposals: All Proposals in response to this RFP are the sole property of County, and subject to the provisions of ORS 192.410-192.505 (Public Records Act).

2.22 Clerical Errors in Awards: County reserves the right to correct inaccurate awards resulting from its clerical errors.

2.23 Rejection of Qualified Proposals: Proposals may be rejected in whole or in part if they attempt to limit or modify any of the terms, conditions, or specifications of the RFP or the Sample Contract.

2.24 Collusion: By responding, the Proposer states that the Proposal is not made in connection with any competing Proposer submitting a separate response to the RFP, and is in all aspects fair and without collusion or fraud. Proposer also certifies that no officer, agent, elected official, or employee of County has a pecuniary interest in this Proposal.

2.25 Evaluation Committee: Proposals will be evaluated by a committee consisting of representatives from County and potentially external representatives. County reserves the right to modify the Evaluation Committee make-up in its sole discretion.

2.26 Commencement of Work: The contractor shall commence no work until all insurance requirements have been met, the Protest of Awards deadline has been passed, any protest have been decided, a contract has been fully executed, and a Notice to Proceed has been issued by County.

2.27 Best and Final Offer: County may request best and final offers from those Proposers determined by County to be reasonably viable for contract award. However, County reserves the right to award a contract on the basis of initial Proposal received. Therefore, each Proposal should contain the Proposer's best terms from a price and technical standpoint. Following evaluation of the best and final offers, County may select for final contract negotiations/execution the offers that are most advantageous to County, considering cost and the evaluation criteria in this RFP.

2.28 Nondiscrimination: The successful Proposer agrees that, in performing the work called for by this RFP and in securing and supplying materials, contractor will not discriminate against any person on the basis of race, color, religious creed, political ideas, sex, age, marital status, sexual orientation, gender identity, veteran status, physical or mental handicap, national origin or ancestry, or any other class protected by applicable law.

2.29 Intergovernmental Cooperative Procurement Statement: Pursuant to ORS 279A and LCRB, other public agencies shall have the ability to purchase the awarded goods and services from the awarded contractor(s) under terms and conditions of the resultant contract. Any such purchases shall be between the contractor and the participating public agency and shall not impact the contactor's obligation to the County. Any estimated purchase volumes listed herein do not include other public agencies and County makes no guarantee as to their participation. Any Proposer, by written notification included with their Proposal, may decline to extend the prices and terms of this solicitation to any and/or all other public agencies. County grants to any and all public serving governmental agencies, authorization to purchase equivalent services or products described herein at the same submitted unit bid price, but only with the consent of the contractor awarded the contract by the County.

SECTION 3
SCOPE OF WORK

3.1. INTRODUCTION

Clackamas County is seeking Proposals from vendors to provide Medical Screening Services.

Please direct all Technical/Specifications or Procurement Process Questions to the indicated representative referenced in the Notice of Request for Proposals and note the communication restriction outlined in Section 2.19.

3.2 BACKGROUND

Clackamas County uses a medical provider to perform medical screening to ensure employees are able to meet pre-employment job classification standards as well as any on-going services that may be required by occupational and health safety rules.

3.3. SCOPE OF WORK

INTRODUCTION:
The Clackamas County Human Resources department is requesting proposals from qualified, independent, and objective Contractors to provide professional occupational health services.

PURPOSE AND OBJECTIVE:

The purpose of this RFP is to obtain: professional and cost proposals covering professional occupational health services, which include but are not limited to: job analyses, functional capacity evaluations, pre-placement examinations and occupational health monitoring from qualified, independent occupational medical provider firms.

Clackamas County requires pre-placement examinations in positions with physical demands and drug screens for selected candidates.

Therefore, Clackamas County's objective is to select one or more occupational medical firm(s) qualified to provide the services listed below.

MEDICAL:

The Contractor will complete a comprehensive medical history assessment for a variety of job candidates in a variety of positions throughout the County to include complete physical examination and physical capacity testing by a physician and/or occupational therapist with emphasis on the neurological and orthopedic problems that might interfere with performing the essential job functions. Types of assessments include:

Job Analyses

- Identify and document job tasks and physical demands
- Develop tests to measure applicant(s) ability to complete job tasks and physical demands
- Validate tests
- Implement tests

Pre-placement exams, to include:

- Vital signs, height, weight, vision and body systems with emphasis on neuromuscular and orthopedic systems
- Comprehensive medical history review
- Audiometry (Hearing) exams

Functional capacity evaluations, to include:

- Heavy Physical demands capacity testing
- Light Physical demands capacity testing
- Return to work or Fit for duty exam

DOT (Dept. of Transportation), to include:

- Physical exam
- Drug analysis screening with chain of evidence procedures in positions where Clackamas County policy allows (pre and post-employment) (DOT and non-DOT)
- Medical review services for positive DOT drug analysis screening

Non-Dot Drug and Alcohol Testing to include:

- Drug and analysis screening with chain of evidence procedures (Non-DOT test – all inclusive, includes collections/lab test/MRO)
- Medical review service for positive non-DOT drug analysis screening
- Breathe Alcohol Analysis screening with chain of evidence procedures

NIOSH approved respiratory testing:

- Respirator Physical
- Pulmonary function test
- Spirometry test

Additional Services (as requested):

- Hepatitis A Vaccination Series
- Hepatitis B Vaccination Series
- Hepatitis C Vaccination Series
- Tetanus Vaccine TDAP – includes administration
- Tuberculosis Skin Test (PPD)
- Blood draw lab test
- Chest X-Ray
- Physician Consult
- TB test review/X-Ray order by MD
- Other testing that may be relevant to position not listed above but may be included on the Contractor's pricelist
- On-site services as needed

Complete physical examinations and physical capacity testing must be performed by licensed medical physicians and/or an occupational therapist familiar with the unique physical demands of the position.

REPORTS:

Following the assessment(s), the results and recommendations are provided, usually within twenty-four to forty-eight (24- 48) hours verbally and a written assessment within five (5) successive business days.

Written reports must be provided to the department evaluating the suitability of the applicant or employee for the job based upon an analysis of all available data, test and interview results. The final written reports must include any reservations that the physician(s) might have regarding the validity or reliability of the results.

CONTRACTOR RESPONSIBILITIES:

The Contractor must be able to:

1) Meet the medical and physical assessment testing requirements needs of Clackamas County.
2) Have multi-appointments for multi-candidates for multi-tests without subcontracting to multiple service providers with the exception of drug analysis screening;
3) Schedule with reasonable time notification and in some cases provide their services almost immediately;
4) Must have qualified and medically certified personnel conducting the medical testing; and,
5) Must be able to provide the necessary report(s), either written and/or verbal based on the County's timelines
6) Must meet all applicable Federal, State and Local laws & regulations, including HIPPA and the Americans with Disabilities Act (ADA) and shall successfully defend the results when challenged.
7) All written reports become property of Clackamas County.

DEPARTMENT RESPONSIBILITIES:

The County will notify the applicant or employee verbally and/or in writing of the requirement to take a medical examination(s) and/or physical capacity evaluation and will give the Contractor's name, address, telephone number so the candidate can call for their appointment based on their schedule and the timeline established by the County. The County will also provide to the Contractor any information that is needed to assist in the conducting of the test(s).

3.3.3. Term of Contract:

The term of the contract shall be from the effective date through **10/31/2025,** with the option for one (1) additional one-year renewal thereafter subject to the mutual agreement of the parties.

3.3.4 Sample Contract: Submission of a Proposal in response to this RFP indicates Proposer's willingness to enter into a contract containing substantially the same terms (including insurance requirements) of the sample contract identified below. No action or response to the sample contract is required under this RFP. Any objections to the sample contract terms should be raised in accordance with Paragraphs 2.2 or 2.3 of this RFP, pertaining to requests for clarification or change or protest of the RFP/specifications, and as otherwise provided for in this RFP. This RFP and all supplemental information in response to this RFP will be a binding part of the final contract.

The applicable Sample Personal Services Contract for this RFP can be found at https://www.clackamas.us/finance/terms.html.

Personal Services Contract (unless checked, item does not apply)

The following paragraphs of the Professional Services Contract will be applicable:

☐ Article I, Paragraph 5 – Travel and Other Expense is Authorized
☒ Article II, Paragraph 28 – Confidentiality
☐ Article II, Paragraph 29 – Criminal Background Check Requirements
☐ Article II, Paragraph 30 – Key Persons
☐ Article II, Paragraph 32 – Federal Contracting Requirements
☐ Exhibit A – On-Call Provision

The following insurance requirements will be applicable:

☐ 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.
☒ 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.
☒ Medical Professional Liability ($1/$3M)
☒ Automobile Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence for Bodily Injury and Property Damage.
☒ Cyber Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence for network security (including data breach), privacy, interruption of business, media liability, and errors and omissions

SECTION 4
EVALUATION PROCEDURE

4.1 An evaluation committee will review all Proposals that are initially deemed responsive and they shall rank the Proposals in accordance with the below criteria. The evaluation committee may recommend an award based solely on the written responses or may request Proposal interviews/presentations. Interviews/presentations, if deemed beneficial by the evaluation committee, will consist of the highest scoring Proposers. The invited Proposers will be notified of the time, place, and format of the interview/presentation. Based on the interview/presentation, the evaluation committee may revise their scoring.

Written Proposals must be complete and no additions, deletions, or substitutions will be permitted during the interview/presentation (if any). The evaluation committee will recommend award of a contract to the final County decision maker based on the highest scoring Proposal. The County decision maker reserves the right to accept the recommendation, award to a different Proposer, or reject all Proposals and cancel the RFP.

Proposers are not permitted to directly communicate with any member of the evaluation committee during the evaluation process. All communication will be facilitated through the Procurement representative.

4.2 Evaluation Criteria

Category	**Points available:**
Proposer's General Background and Qualifications	0-30
Scope of Work	0-35
Fees	0-35
Available points	**0-100**

4.3 Once a selection has been made, the County will enter into contract negotiations. During negotiation, the County may require any additional information it deems necessary to clarify the approach and understanding of the requested services. Any changes agreed upon during contract negotiations will become part of the final contract. The negotiations will identify a level of work and associated fee that best represents the efforts required. If the County is unable to come to terms with the highest scoring Proposer, discussions shall be terminated and negotiations will begin with the next highest scoring Proposer. If the resulting contract contemplates multiple phases and the County deems it is in its interest to not authorize any particular phase, it reserves the right to return to this solicitation and commence negotiations with the next highest ranked Proposer to complete the remaining phases.

SECTION 5
PROPOSAL CONTENTS

5.1. Vendors must observe submission instructions and be advised as follows:

5.1.1. Complete Proposals must be emailed to Procurement@clackamas.us. The subject line of the email must identify the RFP title. Proposers are encouraged to contact Procurement to confirm receipt of the Proposal.

5.1.3. County reserves the right to solicit additional information or Proposal clarification from the vendors, or any one vendor, should the County deem such information necessary.

5.1.4. Proposal may not exceed a total of **30 pages** (single-sided), inclusive of all exhibits, attachments or other information.

Provide the following information in the order in which it appears below:

5.2. Proposer's General Background and Qualifications:

- Description of the firm.
- Credentials/experience of key individuals that would be assigned to this project.
- Description of providing similar services to public entities of similar size within the past five (5) years.
- Description of the firm's ability to meet the requirements in Section 3.
- Description of what distinguishes the firm from other firms performing a similar service.

5.3. Scope of Work

Complete physical examination by a physician with emphasis on the neurological and orthopedic problems that might interfere with performing the essential job functions of the position for which they are being hired.

Place a check (✔) in front of those items that you can provide.

_____Job Analyses

_____Pre-placement exams (comprehensive medical history assessment must be included)

_____Functional capacities testing

_____Return-to-work exams

_____DOT (Dept. of Transportation)

_____Fit for duty exams

_____Non-DOT Drug Analysis Screening with chain of evidence procedures

_____Breathe Alcohol Analysis Screening with chain of evidence procedures

_____Examination by Physician with emphasis on neuromuscular and orthopedic systems

_____NIOSH approved respiratory testing

_____Complete physical examinations must be performed by licensed medical physicians familiar with the unique physical demands of the positions being evaluated (comprehensive medical history assessment must be included)

_____Electronic/written reports as specified in section 3.3 (*please provide examples)*

_____Any addition services as specified in section 3.3 (*please explain*)

5.4. Fees

Complete **Attachment #1 Fee Schedule** for each service that you provide and the associated rate. If you do not offer the service, leave blank. For each Contract Year the fees shall be fixed. By September 1st of each Contract year, the Contractor may request an increase in the fees (for the next Contract year) in an amount not to exceed the increase in the Consumer Price Index, West Region (CPI-U) or a maximum of four percent (4%). Any such increase shall only be approved through an Amendment to the Contract.

5.5. References

Provide at least three (3) references from clients your firm has served similar to the County in the past three (3) years, including one client that has newly engaged the firm in the past thirty-six (36) months and one (1) long-term client. Provide the name, address, email, and phone number of the references. Please note the required three references may not be from County staff, but additional references may be supplied

5.6. Completed Proposal Certification (see the below form)

PROPOSAL CERTIFICATION
RFP #2021-65

Submitted by:_____
(Must be entity's full legal name, and State of Formation)

Each Proposer must read, complete and submit a copy of this Proposal Certification with their Proposal. Failure to do so may result in rejection of the Proposal. By signature on this Proposal Certification, the undersigned certifies that they are authorized to act on behalf of the Proposer and that under penalty of perjury, the undersigned will comply with the following:

SECTION I. OREGON TAX LAWS: As required in ORS 279B.110(2)(e), the undersigned hereby certifies that, to the best of the undersigned's knowledge, the Proposer is not in violation of any Oregon Tax Laws. For purposes of this certification, "Oregon Tax Laws" means the tax laws of the state or a political subdivision of the state, including ORS 305.620 and ORS chapters 316, 317 and 318. If a contract is executed, this information will be reported to the Internal Revenue Service. Information not matching IRS records could subject Proposer to 24% backup withholding.

SECTION II. NON-DISCRIMINATION: That the Proposer has not and will not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation, gender identity, national origin, or any other protected class. Nor has Proposer or will Proposer discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a disadvantaged business enterprise, a minority-owned business, a woman-owned business, a business that a service-disabled veteran owns or an emerging small business that is certified under ORS 200.055.

SECTION III. CONFLICT OF INTEREST: The undersigned hereby certifies that no elected official, officer, agent or employee of Clackamas County is personally interested, directly or indirectly, in any resulting contract from this RFP, or the compensation to be paid under such contract, and that no representation, statements (oral or in writing), of the County, its elected officials, officers, agents, or employees had induced Proposer to submit this Proposal. In addition, the undersigned hereby certifies that this proposal is made without connection with any person, firm, or corporation submitting a proposal for the same material, and is in all respects fair and without collusion or fraud.

SECTION IV. COMPLIANCE WITH SOLICITATION: The undersigned further agrees and certifies that they:

1. Have read, understand and agree to be bound by and comply with all requirements, instructions, specifications, terms and conditions of the RFP (including any attachments); and
2. Are an authorized representative of the Proposer, that the information provided is true and accurate, and that providing incorrect or incomplete information may be cause for rejection of the Proposal or contract termination; and
3. Will furnish the designated item(s) and/or service(s) in accordance with the RFP and Proposal; and
4. Will use recyclable products to the maximum extend economically feasible in the performance of the contract work set forth in this RFP.

Name:_____ Date:_____

Signature:_____ Title:_____

Email:_____ Telephone:_____

Oregon Business Registry Number:_____ OR CCB # (if applicable):_____

Business Designation (check one):
☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Non-Profit ☐ Limited Liability Company

☐ Resident Quoter, as defined in ORS 279A.120
☐ Non-Resident Quote. Resident State:_____

ATTACHMENT #1 FEE SCHEDULE
(Please complete and return)

SERVICES	Service Offered (X if Yes)	FEE(S)
Job Analyses/Physical Capacity Test Creations:		$ -
Identify and document job tasks and physical demands		$ -
Develop tests to measure		$ -
Validate tests		$ -
Implement tests		$ -
Pre-Placement Exams to include:		$ -
Vital signs, height, weight, vision (Snellen) and body systems with emphasis on neuromuscular and orthopedic systems		$ -
Comprehensive medical history review		$ -
Audiomety (hearing) exams		$ -
Functional Capacity Evaluations to include:		$ -
Heavy physical demands capacity testing		$ -
Light physical demands capacity testing		$ -
Return to work for "fit for duty" exams		$ -
DOT (Dept. of Transportation) to include:		$ -
Physical exam per DOT regulations		$ -
Drug analysis screening with chain of evidence procedures (DOT Test - all inconclusive (includes collection/lab test/MRO)		$ -
Medical review services for positive DOT drug analysis screening		$ -
Breath alcohol analysis screening w/chain of evidence procedures		$ -
DOT qualification - this is a reduced fee if adding DOT medical certification to a pre-placement medical exam		$ -
NON-DOT Drug and Alcohol to include:		$ -
Drug analysis screening with chain of evidence prodecures (Non-DOT Test - all inconclusive (includes collection/lab test only)		$ -
Medical review services for positive non-DOT drug analysis screening		$ -
Breath alcohol analysis screening with chain of evidence procedures		$ -
Non-DOT UDS observation fee		$ -
NIOSH Approved Respiratory Testing:		$ -
Respirator physical (includes respirator questionnaire)		$ -
Pulmonary function test (spirometry)		$ -
Respirator questionniare processing (if mailed in)		$ -
Respirator fit testing (examinee supplies the mask)		$ -
Respirator qualification - this should be a reduced fee if adding respirator clearance to a medical exam		$ -
DPSST F2T Exams to include:		$ -
Vital signs, height, weight, vision (Snellen) and body systems with emphasis on neuromuscular and orthopedic systems		$ -
Audiogram		$ -
Ishihara color test		$ -
Titmus vision test		$ -
Additional Services (as needed/requested):		$ -

SERVICES	Service Offered (X if Yes)	FEE(S)
Vaccination Assessments		$ -
Hepatitis A vaccination series (2 shot series)		$ -
Blood draw and lab test for Hepatitis A		$ -
Hepatitis B vaccination series (3 shot series)		$ -
Blood draw and lab test for Hepatitis B		$ -
Hepatitis C Blood draw and lab test		$ -
Hepatitis A/B Vaccine HEPA-HEPB Adult IM		$ -
Tetanus vaccine TDAP - includes administration		$ -
Tuberculosis skin test (PPD)		$ -
TB test review/X-Ray order by MD		$ -
Chest X-Ray		$ -
Blood Lead w/ZPP		$ -
Asbestos exam		$ -
B-Reader		$ -
Maritime exam		$ -
Flu - Annually		$ -
MMR - if born 1957 or later		$ -
Measles/Mumps/Rubella Virus Live SubQ		$ -
Rubeola Antibody		$ -
Rubella Antibody		$ -
Mumps Antibody		$ -
Varicella Virus Vaccine Live SubQ		$ -
Varicella Zoster Antibody		$ -
Tdap - Booster every 10 years		$ -
Tdap vaccine		$ -
Venipuncture		$ -
Quantiferon Gold		$ -
Physician Lab Review		$ -
Physician Consult		$ -
On-Site Services - Professional Fees - MD onsite per hour		$ -
On-Site Services - Professional Fee - NP onsite per hour		$ -
On-Site Services - Professional Fee - RN onsite per hour		$ -
On-Site Services - Professional Fee - MA onsite per hour		$ -
On-Site Each Additional Hour		$ -
Other charges that may apply:		
Record review brief		$ -
Record review extended		$ -
Exam follow-up brief		$ -
No show fee		$ -

Exhibit B
ADDITIONAL FEDERAL TERMS AND CONDITIONS

As used herein, "Contractor" means **Providence Health & Services - Oregon**, and "County" means Clackamas County, a political subdivision of the State of Oregon.

1. The County intends that all or a portion of the consideration paid to Contractor will be eligible for reimbursement by one or more federal agencies including, but not limited to, the Federal Emergency Management Agency ("FEMA"). This Contract is subject to the additional terms and conditions required by federal law for a federal award. All terms and conditions required under applicable federal law for a federal reward including, but no limited to, 2 C.F.R. § 200.326 and 2 C.F.R. § Pt. 200, App. II, are hereby incorporated by this reference herein.

2. Termination. This Contract may be terminated by mutual agreement of the parties or by the County for one of the following reasons: (i) for convenience upon thirty (30) days written notice to Contractor; or (ii) at any time the County fails to receive funding, appropriations, or other expenditure authority as solely determined by the County.

3. By execution of this Contract, Contractor hereby certifies that it and all subcontractors will comply with (i) all Federal statutes relating nondiscrimination, including, but not limited to: Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis race, color or national origin; Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681 et seq.), which prohibits discrimination on the basis of sex; the Age Discrimination Act of 1975, as amended (29 U.S.C. §§6101 et seq.), which prohibits discrimination on the basis of age; the Rehabilitation Act of 1973, as amended (29 U.S.C. §§793 et seq.), which prohibits discrimination against requires affirmative action for qualified individuals with disabilities; the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. §§4541 et seq.), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; §§523 and 527 of the Public Health Service Act of 1912 (4s U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; Title VII of the Civil Rights Act of 1969 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; any other discrimination provisions in the specific statute(s) under which for Federal assistance is being made; and the requirements of any other nondiscrimination statute(s) which may apply; (ii) will comply with the Byrd Anti-Lobbying Amendment (31 U.S.C. 1352 et. seq.), and shall file the required certification if the award is $100,000 or more; and (iii) will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

4. If this Contract involves a federal award that meets the definition of a "funding agreement" under 37 CFR § 401.2 (a), and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

5. If this Agreement is in excess of $150,000, Contractor certifies that it and all subcontractors will 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. Contractor shall include these requirements in all contracts with subcontractors receiving more than $150,000.

6. If this Agreement is in excess of $100,000 and involves the employment of mechanics or laborers, Contractor and all subcontractors will comply with all applicable standards, orders or regulations issued pursuant to the Contract Work Hours and Safety Standards Act 40 USC §§3701 et seq. as supplemented by Department of Labor regulations at 29 C.F.R. Part 5. See 2 C.F.R. Part 200, Appendix II, ¶ E. Under 40 U.S.C. § 3702, each contractor must be required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. Further, no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous, or dangerous. Contractor shall include and require all providers to include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section.

7. Contractor shall comply with 2 CFR 180.220 and 925. These regulations restrict 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. Contractor is responsible for further requiring the inclusion of a similar term or condition in any subsequent lower tier covered transactions. Contractor 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 E.O. 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. Contractor is required to verify that none of the Contractor's principals (defined at 2 C.F.R. 180.995) or its affiliates (defined at 2 C.F.R. 180.905) are excluded (defined at 2 C.F.R. 180.940) or disqualified (defined at 2 C.F.R. 180.935). The Contractor must comply with 2 C.F.R. pt. 180, subpart C and 2 C.F.R. pt. 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction that Contractor enters into. This certification is a material representation of fact relied upon by the County. If it is later determined that the Contractor did not comply with 2 C.F.R. pt. 180, subpart C and 2 C.F.R. pt. 3000, subpart C, then in addition to remedies available to the County, the Federal Government may pursue available remedies, including but not limited to suspension and/or debarment.

8. Record Retention. Contractor will retain and keep accessible all such financial records, books, documents, papers, plans, records of shipments and payments and writings that are directly related to this Agreement for a minimum of six (6) years, or such longer period as may be required by the federal agency or applicable state law, following final payment and termination of this Agreement, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever date is later, according to 2 CFR 200.333-337. Contractor agrees to provide to the County, to the FEMA Administrator, to the Comptroller General of the United States, or to any of their authorized representatives, access to any books, documents, papers, and records of the Contractor which are directly pertinent to this contract for the purposes of making audits, examinations, excerpts, and transcriptions. Contractor agrees to permit any of the foregoing parties to reproduce by any means whatsoever or to copy excerpts and transcriptions as reasonably needed. The Contractor agrees to provide the FEMA Administrator or the Administrator's authorized representative's access to construction or other work sites pertaining to the Work being completed under the Contract. In compliance with the Disaster Recovery Act of 2018, the County and the Contractor acknowledge and agree that no language in this Contract is intended to prohibit audits or internal reviews by the FEMA Administrator or the Comptroller General of the United States.

9. DHS Seal, Logo, and Flags: Contractor shall not use the DHS seal(s), logos, crests, or reproductions of flags or likenesses of DHS agency officials without specific FEMA pre-approval.

10. Compliance with Federal Law, Regulations, and Executive Orders: This is an acknowledgement that FEMA financial assistance may be used to fund this Contract only. Contractor will comply with all federal law, regulations, executive orders, FEMA policies, procedures, and directives.

11. No Obligation by Federal Government: The Federal Government is not a party to this Contract and is not subject to any obligations or liabilities to the non-Federal entity, Contractor, or any other party pertaining to any matter resulting from the contract.

12. Program Fraud and False or Fraudulent Statements or Related Acts: Contractor acknowledges the 31 U.S.C. Chapter 38 (Administrative Remedies for False Claims and Statements) applies to the Contractor's actions pertaining to this Contract.

13. Contractor will comply with all requirements of 2 CFR 200.321.

14. Procurement of Recovered Materials (Reference 2 CFR 200.322): Contractor must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. Information about this requirement, along with the list of EPA-designate items, is available at EPA's Comprehensive Procurement Guidelines web site, https://www.epa.gov/smm/comprehensive-procurement-guideline-cpg-program.

15. Byrd Anti-Lobbying Amendment, 31 U.S.C. § 1352 (as amended). Contractors who apply or bid for an award of $100,000 or more shall file the required certification, set forth below. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, officer or employee of Congress, or an employee of a Member of Congress in connection with obtaining any Federal contract, grant, or any other award covered by 31 U.S.C. § 1352. Each tier shall also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the recipient who in turn will forward the certification(s) to the awarding agency.

    Contractor hereby makes the following certification:

    Byrd Anti-Lobbying Amendment Certification
    for Contracts, Grants, Loans, and Cooperative Agreements

    The undersigned certifies, to the best of his or her knowledge and belief, that:

    A. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

    B. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance

with its instructions.

C. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

The Contractor certifies or affirms the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, the Contractor understands and agrees that the provisions of 31 U.S.C. Chap. 38, Administrative Remedies for False Claims and Statements, apply to this certification and disclosure, if any.

Aimee L Tinkle Digitally signed by Aimee L Tinkle
Date: 2021.11.04 10:00:13 -07'00'

Signature of Contractor's Authorized Official

Aimee Tinkle, Sr Manager

Name and Title of Contractor's Authorized Official

11/04/2021

Date

EXHIBIT C
CONTRACTOR'S PROPOSAL

REQUEST FOR PROPOSAL

Clackamas County
RFP #2021-65
Medical Screening Services

Providence Health & Services – Oregon
Providence Medical Group
DBA Providence Occupational Medicine

September 24, 2021

PROVIDENCE
Health & Services

September 24, 2021

Kim Randall
Clackamas County, Contract Analyst
Email: procurement@clackamas.us

Dear Ms. Randall:

Providence Health & Services Oregon, Providence Medical Group DBA Providence Occupational Medicine is pleased to respond to RFP #2021-65 Medical Screening Services.

We are an experienced, full service Occupational Medicine program successfully serving employers in Oregon for over 30 years. We agree that the services requested by Clackamas County are very important in maintaining a healthy and productive workforce and we would be pleased to continue our partnership with the County. We understand the scope and are able to provide all of the services discussed in the RFP.

The following people able to negotiate in the contracting process:

Aimee Tinkle, Clinic Manager
(Legal Representative for contractual matters)
Providence Health & Services
4400 NE Halsey St, Bldg. 2 4th Floor
Portland, OR 97213
Phone: 971-369-0823
Email: Aimee.Tinkle@providence.org

Laura Cook, Account Manager Occupational Medicine
Providence Workplace Health Services
4400 NE Halsey St, Bldg. 1 Suite 245
Portland, OR 97213
Phone: 503-215-4854 Fax: 971-712-2184
Email: Laura.Cook@providence.org

Thank you for this opportunity to share information with you about Providence Occupational Medicine.

Sincerely,

Aimee L Tinkle
Aimee L. Tinkle, Senior Manager Occupational Medicine

Laura Cook
Laura Cook, Account Manager, Occupational Medicine

PROPOSAL CERTIFICATION
RFP #2021-65

Submitted by: Providence Health & Services Oregon /Providence Medical Group/ DBA Providence Occupational Medicine

(Must be entity's full legal name, and State of Formation)

Each Proposer must read, complete and submit a copy of this Proposal Certification with their Proposal. Failure to do so may result in rejection of the Proposal. By signature on this Proposal Certification, the undersigned certifies that they are authorized to act on behalf of the Proposer and that under penalty of perjury, the undersigned will comply with the following:

SECTION I. OREGON TAX LAWS: As required in ORS 279B.110(2)(e), the undersigned hereby certifies that, to the best of the undersigned's knowledge, the Proposer is not in violation of any Oregon Tax Laws. For purposes of this certification, "Oregon Tax Laws" means the tax laws of the state or a political subdivision of the state, including ORS 305.620 and ORS chapters 316, 317 and 318. If a contract is executed, this information will be reported to the Internal Revenue Service. Information not matching IRS records could subject Proposer to 24% backup withholding.

SECTION II. NON-DISCRIMINATION: That the Proposer has not and will not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation, gender identity, national origin, or any other protected class. Nor has Proposer or will Proposer discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a disadvantaged business enterprise, a minority-owned business, a woman-owned business, a business that a service-disabled veteran owns or an emerging small business that is certified under ORS 200.055.

SECTION III. CONFLICT OF INTEREST: The undersigned hereby certifies that no elected official, officer, agent or employee of Clackamas County is personally interested, directly or indirectly, in any resulting contract from this RFP, or the compensation to be paid under such contract, and that no representation, statements (oral or in writing), of the County, its elected officials, officers, agents, or employees had induced Proposer to submit this Proposal. In addition, the undersigned hereby certifies that this proposal is made without connection with any person, firm, or corporation submitting a proposal for the same material, and is in all respects fair and without collusion or fraud.

SECTION IV. COMPLIANCE WITH SOLICITATION: The undersigned further agrees and certifies that they:

1. Have read, understand and agree to be bound by and comply with all requirements, instructions, specifications, terms and conditions of the RFP (including any attachments); and
2. Are an authorized representative of the Proposer, that the information provided is true and accurate, and that providing incorrect or incomplete information may be cause for rejection of the Proposal or contract termination; and
3. Will furnish the designated item(s) and/or service(s) in accordance with the RFP and Proposal; and
4. Will use recyclable products to the maximum extend economically feasible in the performance of the contract work set forth in this RFP.

Name: Aimee L Tinkle Date: 9/16/2021

Signature: Aimee L Tinkle Title: Sr Manager

Email: aimee.tinkle@providence.org Telephone: 971-369-0823

Oregon Business Registry Number: 037230-12 OR CCB # (if applicable): _____

Business Designation (check one):

☒ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Non-Profit ☐ Limited Liability Company

☒ Resident Quoter, as defined in ORS 279A.120

☐ Non-Resident Quote. Resident State: _____

PROVIDENCE
Health & Services

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General Background and Qualifications

Providence Occupational Medicine Overview

Providence Occupational Medicine is part of Providence Health & Services - Oregon, a not-for-profit organization that has served the Northwest since 1856. Providence Occupational Medicine is a multi-clinic program that provides comprehensive occupational health services in the Portland metropolitan area, as well as Medford, Newberg and Hood River. The Providence Occupational Medicine program has served over 13,000 employers in our community since 1988. Many of the employers are state, local and federal government agencies. Our success comes from our commitment on continual improvement and coordination with our employer customers to help keep employees healthy, safe and at work.

Project Team – Portland Metro Area Clinics

Our entire program has 70+ staff members led by our Medical Director, Andrew Singh, MD our Sr. Manager, Aimee Tinkle and Clinic Manager, Shaderra Stevens. As a team we put customer service, patient care and client care as top objectives.

Project Management and Key Personnel
Clinic Level:
Sandra Soumokil, Supervisor Occupational Medicine Bridgeport & Newberg– Project Manager
Colleen Bundy, Supervisor Occupational Medicine Clackamas – Project Manager
Lindsey Shelton, Supervisor Occupational Medicine Mill Plain & The Plaza – Project Manager
Mona Ando Cooper, Supervisor Occupational Medicine Tanasbourne - Project Manager

Clinical Operations:
Michelle Varner, Supervisor for Call Center (Scheduling Desk) and Business Office
Shaderra Stevens, Clinic Manager for Providence Occupational Medicine Oregon/SWWA Region
Aimee Tinkle, Sr. Manager for Providence Occupational Medicine Oregon/SWWA Region
Shannon Sexton, RN, Nurse Quality Supervisor for Providence Occupational Medicine Oregon/SWWA Region
Andrew Singh, MD, Occupational Medicine Program Medical Director Oregon/SWWA Region

Sales Office:
Laura Cook, Account Manager Occupational Medicine – Account Management
Michelle Cribbs, Account Executive Providence Sales & Service – Account Management

Sandra Soumokil, Supervisor Occupational Medicine Bridgeport and Newberg
Sandra has 17 years of experience working for Providence Occupational Medicine in progressively responsible roles of OH Tech, Medical Assistant, Lead Medical Assistant and Clinic Supervisor. Sandra oversees the day-to-day functions of both Bridgeport and Newberg clinics. Sandra will be available to Clackamas County for inquiries, to resolve issues and to generally ensure a smooth experience for Clackamas County, its candidates, and employees.

Colleen Bundy, Supervisor Occupational Medicine Clackamas
Colleen has 9 years of experience working for Providence in progressively responsible roles of Medical Assistant, Clinical Care Coordinator, Operations Coordinator, and Clinic Supervisor. The last two years have been in our Clackamas clinic as Clinic Supervisor where she oversees the day-to-day functions of that clinic. Colleen will be available to Clackamas County for inquires, to resolve issues and to generally ensure a smooth experience for Clackamas County, its candidates, and employees.

Lindsey Shelton, Supervisor Occupational Medicine Mill Plain and The Plaza
Lindsey has 22 years of experience working with various disciplines and organizations throughout the northwest region. The last 7 years have been with Providence at different locations in progressively responsible roles of Clinic Care Coordinator, and Clinic Supervisor. Lindsey oversees the day-to-day functions of the Mill Plain and The Plaza clinics. Lindsey will be available to Clackamas County for inquires, to resolve issues and to generally ensure a smooth experience for Clackamas County, its candidates, and employees.

Mona Ando Cooper, Supervisor Occupational Medicine Tanasbourne
Mona has 23 years of experience working for Providence Occupational Medicine in progressively responsible roles of Medical Assistant, Lead Medical Assistant and Clinic Supervisor. Mona oversees the day-to-day functions of the Tanasbourne clinic. Mona will be available to Clackamas County for inquires, to resolve issues and to generally ensure a smooth experience for Clackamas County, its candidates and employees.

Michelle Varner, Supervisor Call Center (Scheduling Desk) and Business Office
Michelle oversees the day-to-day functions of our Call Center (Scheduling Desk) as well as our Business Office. Michelle will be available for Clackamas County inquiries, to resolve issues and to generally ensure a smooth experience for Clackamas County, its candidates, and employees.

Shaderra Stevens, Clinic Manager Providence Occupational Medicine Oregon/SWWA Region
Shaderra Stevens brings 20 years of leadership experience. Last 5 years have been with Providence. She was a supervisor with the Women and Children's department for 4 1/2 years then transitioned to occupational medicine where she oversees the day-to-day operations for 7 of our OR/SWWA clinics. Shaderra has a strong background with OR & WA workers compensation rules and regulations.

Aimee Tinkle, Clinic Manager for Providence Occupational Medicine Oregon/SWWA Region
Aimee Tinkle brings 23 years' experience working for Providence Occupational Medicine in progressively responsible roles of Medical Assistant, Lead Medical Assistant, Clinic Supervisor and OR Region Clinic Manager. Aimee possesses a Bachelor of Science in Health Administration, and she holds a Master of Business Administration degree.

Shannon Sexton, BSN, RN Nurse Quality Supervisor for Providence Occupational Medicine Oregon/SWWA Region
Shannon has recently joined the Occupational Medicine team as the Nurse Quality Supervisor. Her focus is on quality improvements, safe care standards, and patient satisfaction. She brings over 30 years of nursing experience in a variety of settings. She has progressed from a Licensed Practical Nurse to a Registered Nurse and holds a Bachelor of Science Degree in Nursing.

Andrew Singh, MD, Medical Director Providence Occupational Medicine Oregon/SWWA Region
Dr. Singh received his undergraduate degree with High Honors in Chemistry from Wesleyan University in 1993. Completed medical school from St. Louis University in 2000. Obtained MPH (Masters of Public Health) from St. Louis University in 2004. Residency trained in Occupational Medicine, completed 2004. Board Certified in Occupational Medicine. Dr. Singh has 16 years of Occupational Medicine experience in several different states. We are most honored to have him as our Medical Director for Providence Occupational Medicine overseeing all 8 clinics in OR and SWWA since 2018.

Trevor Tash, Occupational Therapist
Trevor has been with Providence Rehabilitation for 15 years. Trevor is responsible for developing the Physical Capacity Testing for Providence Workplace Health Services clients. Some of Trevor's additional job functions include performing Physical Capacity Evaluations: detailed testing of worker's abilities and tolerances for performing work. Assessments are performed for Workers' Compensation assessments, Disability assessments and Attorney requests.

Laura Cook, Account Manager Occupational Medicine
Laura has 20 years' experience in the medical field with 15 of those years working for Providence Occupational Medicine in progressively responsible roles from Client Services to Account Management. Laura's role with Clackamas County will be to manage the account in our system, make any necessary changes/updates, answer questions, serve as a resource, and general work in conjunction with the clinic operations and staff to ensure Clackamas County's satisfaction with our services.

Michelle Cribbs, Account Executive Providence Sales & Service
Michelle earned a BS from Oregon State University in Merchandising and Business. She has over 30 years of sales and client support experience with the last 11 years in medical sales with the last 6 years including occupational medicine. Michelle is passionate about client relationships and is dedicated to customer satisfaction and support. She will serve as a resource and advocate and will work in conjunction with clinic operations and staff to ensure Clackamas County's satisfaction with our services.

Medical Clinics and Practitioners:

Providence Occupational Medicine – Bridgeport
18040 SW Lower Boones Ferry Rd., Suite 100, Tigard, OR 97224
Monday – Friday 8AM to 5PM
Providence Occupational Medicine | Bridgeport, Oregon | Providence Oregon

- Husameddin S. El Bakri, MD
- Andrew Singh, MD Board Certified Occupational Medicine (Friday's only)

Providence Occupational Medicine – Clackamas
9290 SE Sunnybrook Blvd., Suite 210, Clackamas, OR 97015
Monday – Friday 7AM to 6PM – no providers available after 5PM
Providence Occupational Medicine | Clackamas, Oregon | Providence Oregon

- Randolph Cribbs, MD
- Michael Savage, MD
- Jesse Powell, MD
- Joseph Smith, MD, MPH, Board Certified Occupational Medicine
- Kimberly Crihfield, MD
- Kristian Flores, MD

Providence Occupational Medicine – Mill Plain
315 SE Stone Mill Dr., Suite 200, Vancouver, WA 98682
Monday – Friday 8AM to 5PM
Providence Occupational Medicine - Mill Plain | Vancouver, Washington | Providence Oregon

- Mary Pierce, ANP
- Andy Humes, MD

Providence Occupational Medicine – Tanasbourne
10670 NE Cornell Rd., Suite 204, Hillsboro, OR 97124
Monday – Friday 7AM to 6PM – no providers available after 5PM
Providence Occupational Medicine - Tanasbourne | Hillsboro, Oregon | Providence Oregon

- Volodymyr Dovhyy, MD
- Yuriko Lee, FNP
- Andrew Singh, MD, Board Certified Occupational Medicine (Wednesday's only)

Providence Occupational Medicine – The Plaza
5050 NE Hoyt St., Suite B48, Portland, OR 97213
Monday – Friday 7AM to 5:30PM
Providence Occupational Medicine-The Plaza | Providence Oregon

- Crystal Bell, NP
- Andrew Singh, MD Board Certified Occupational Medicine (Monday's only)

*Providence Occupational Medicine – Newberg
1001 Providence Drive Newberg, OR 97132
Monday – Friday 8AM to 5PM
Providence Occupational Medicine | Newberg, Oregon | Providence Oregon

- James Cooke, NP

*Note: PCT's, audiograms and respirator fit testing are not available at the Newberg clinic

Department Contact Information:

Call Center (Scheduling Desk)
Phone: 503-215-2890 option 4
Email: orregoms@providence.org

Central Support Team – for medical records (e.g., missing, illegible etc.)
Phone: 503-215-2890 option 3
Email: orregomcst@providence.org

Billing Office
Phone: 503-215-2557 – not a manned phone, must leave message
Email: providenceocchealth@providence.org

Clinic Staff: Due to space issues, we are unable to list all clinic, medical assistant, and technician staff members. Our program is blessed to have the following experienced employees working for us. This list does not include medical, management or sales/service staff individually mentioned above.

- Medical Assistants
- Drug/Alcohol Technicians (dedicated position)
- Patient Relations Representatives (Front desk staff; some are trained collectors)

Our staff possesses the necessary training and certifications to perform all services including:

- Occupational Hearing Conservationist basic certification approved for the Council for Accreditation of Occupational Hearing Conservationists (CAOHC).
- Approved pulmonary function testing, National Institute for Occupational Safety and Health (NIOSH).
- Urine Drug Test Collector Training, in accordance with the U.S. Dept. of Transportation Testing Procedures 49 CFR Part 40.
- Breath Alcohol Technician Training, in accordance with the U.S. Dept. of Transportation Testing Procedures 49 CFR Part 40.

Management Approach

The project managers for each clinic will oversee the clinic support staff, including registrars and medical assistants who assist the clinic providers, providing medical ancillary services, registering patients, and preparing reports for our clients. Our staff receives ongoing education about changes in client specific protocols and medical service protocols.

Key Personnel

Our key personnel work at all clinic locations with clients as needs arise. The amount of time needed for this project will vary for each team member based on the needs of Clackamas County. Staff works closely together to ensure that business needs are met in the most responsive, cost-effective manner possible. We partner with our clients on an ongoing basis to address changes that might be needed to improve services we deliver. Modifications to protocols are made in a timely manner based on written request from Clackamas County.

Experience with Similar Projects

Our program works with many governmental agencies and municipalities on similar projects. Many are long standing clients of ten to twenty years, or more, examples are:

City of Portland – (20+ years) - Preplacement, Respirator, Firefighter, Police/DPSST, Fit for Duty, Medical Surveillance Exams, DOT drug screen collections and select general employment drug testing, Physical Capacity Tests and Physical Capacity Test Development

City of Oregon City – (15+ years) – Preplacement, Respirator, Police/DPSST Exams, Fit for Duty, Medical Surveillance Exams, DOT drug screen collections and employment drug testing, Physical Capacity Tests and Physical Capacity Test Development

Washington County – (15+ years) – Preplacement, Respirator, Police/DPSST, Fit for Duty, DOT drug screen collections and general employment drug testing, Physical Capacity Tests and Physical Capacity Test Development.

Tualatin Valley Water District – (20+ years) – Preplacement, Respirator, Fit for Duty Exams, DOT and express/onsite employment drug testing, Physical Capacity Tests.

Providence Occupational Medicine-Oregon strives to be the premier occupational service provider in our service areas throughout Oregon and SW Washington by providing the highest quality services in a timely manner at competitive rates. Our organizations core values of compassion, dignity, justice, excellence, and integrity drive us to exceed expectations at every opportunity. We actively monitor the overall quality and timeliness of services provided and implement quality control processes when improvement opportunities are identified.

Providence Occupational Medicine is obligated by law to protect patient/examinee Protected Health Information (PHI). All medical records will remain the property of Providence Occupational Medicine. Copies of records that can be released will be provided to Clackamas County.

We have established protocols for each type of service or exam type, which includes a list of standard and optional services for each protocol. The database is maintained and updated regularly. We use InDemand Interpreting Services for language translation services for employers who wish to request translation services for exams.

Providence Occupational Medicine provides flexibility in working with our clients to meet their business needs. Our providers, management team and support staff understand the importance of accurate, unbiased, and confidential medical determinations to both the candidate/employee and employer in maintaining a safe workplace and community; and as such our medical determinations are based on sound medical judgment in conjunction with information specific to the exposures faced by Clackamas County employees. (For example, we keep job descriptions/job analyses on file for our medical providers to review as needed. We also offer medical provider tours of your facilities or work locations to ensure their familiarity with the work performed by County employees).

All providers and staff receive ongoing training regarding our program's medical protocols and standard procedures as well as client specific protocols. Monthly staff meetings at each clinic assure consistency of service delivery. The medical assistants are CAOHC certified in audiometry, NIOSH certified in spirometry. They are all certified to provide federally mandated urine drug screens and breath alcohol testing, medical assistants also receive annual competency testing and ongoing training for services they provide.

Proposer Qualifications

Summaries of Exam Types for Portland Metro Area Clinics:

Job Task Analysis and Physical Capacity Test Creation Process

DESCRIPTION OF JTA
A JTA is a process to identify and determine in detail the particular job duties and requirements and the relative importance of these duties for a given job. It can be used to define valid and defensible position duties and responsibilities, determine valid entry level job requirements, and determine legitimate medical and/or physical job requirements, amongst other various uses. An important concept of the JTA is that the analysis is conducted of the job, not the person. While JTA data may be collected from incumbents through interviews or questionnaires, the product of the analysis is a description or specifications of the job, not a description of the person.

What aspects of the job are analyzed in a JTA?

- **Duties and Tasks:** The basic unit of a job is the performance of specific tasks and duties. Information to be collected about these items may include: frequency, duration, effort, skill, complexity, equipment, standards, etc.
- **Environment:** This may have a significant impact on the physical requirements to be able to perform a job. The work environment may include unpleasant conditions such as offensive odors and temperature extremes. There may also be definite risks to the incumbent such as chemical contact, restricted spaces, high elevations, noise, vibrations, slippery surfaces, lighting, vision impairments, etc.
- **Tools and Equipment:** Some duties and tasks are performed using specific equipment and tools. Equipment may include personal protective clothing (PPE). These items need to be specified in a JTA.

Other possible applications of a JTA are:

- **Basic Entry Level Requirements:** What knowledge, skills, and abilities are required for prospective candidates?
- **Medical Standards:** Some jobs are of sufficient risk and demand on physical skills, medical standards are necessary. With the addition of a medical professional review of data from the JTA, organizations can maintain and defend job-related medical standard and physical capabilities requirements.
- **Basic Work Requirements:** The fundamental, minimum performance standards for the job.
- **Training Curricula:** Determining valid, job related training content.

DESCRIPTION OF PCT

A PCT is a fifteen-to-thirty-minute evaluation proctored by a Medical Assistant, where these services can be performed (e.g., Bridgeport (Tigard), Clackamas, Tanasbourne (Hillsboro), The Plaza (Portland) and Mill Plain (Vancouver, WA).

This test includes a series of physical movements designed to test physical strength, range of motion, stamina, and tolerance to functional activities, including lifting and carrying. These tests are custom designed by a professional Occupational or Physical Therapist for a specific job title at a specific employer.

PCTs are only administered following a pre-placement or fit for duty physical examination in which the examining medical provider clears the candidate/employee to participate in the PCT. The PCT helps take the guesswork out of determining if a candidate/employee is physically able to perform a job and helps identify potential ADA issues and/or necessary work restrictions or accommodations.

THE JTA/PCT CREATION PROCESS

Step 1 Information Gathering:

Employer notifies the Workplace Health Services Account Manager of the need for a new or modified JTA and/or PCT. The Account Manager will provide a questionnaire to employer to be completed by the incumbent or other employee familiar with the job in question. In addition to the completed questionnaire, the employer provides to the Account Manager any existing information on the position such as Job Description, Job Task Analysis, prior/old PCT, etc.

Occasionally an employer will have two or more positions that are very similar. In this case, information on the similar position(s) may be used if little or no information exists on the job in question. The Account Manager will initiate the request for a new JTA/PCT with the OT/PT and will assume the “project lead” role for the Providence employees involved.

The Account Manager will explain the process to the employer, facilitate communication between parties, facilitate scheduling of the onsite visit, meetings, phone conferences (and attend as appropriate), and generally ensure appropriate progress and outcome.

Step 2 Onsite Observation/Measurements/Interviews:

The Account Manager and/or Account Executive (if available) and OT/PT visits employer to observe the job in progress, take measurements and interview incumbent(s). This process usually takes 1-2 hours. Observation of manufacturing or production positions in which the employee performs the same task repeatedly may be completed in less time.

In the case of the position with varied tasks (especially field positions) it is not feasible to observe all elements of a position within this time frame, nor is it affordable (or necessary) to have additional hours of observation. This challenge is overcome through advanced preparation for the onsite visit, interview of the incumbent(s), and significant review/validation of the JTA/PCT in later steps.

Employers may assist in ensuring a quality result by arranging to have an incumbent demonstrate the tasks he/she performs for the OT/PT. (If one incumbent is not familiar with all elements of the position, two or more incumbents may participate in the

demonstration/interview. If an incumbent is not available, a past worker in that position or current supervisor familiar with the position will suffice).

Demonstration should focus on the most physically difficult tasks the employee performs in a day/week/month, and those tasks resulting in the most employee injuries (if known).

During the onsite visit, the OT/PT may take pictures, will take weights and measurements, and will ask questions regarding the job tasks, frequency, volumes/production quotas, etc. If the incumbent is not able to answer these questions it is important to have a knowledgeable supervisor or other employer representative available.

Step 3 Creation of the Job Task Analysis (JTA):
The OT/PT will utilize the information obtained during the onsite visit/interview to create a draft Job Task Analysis. This draft will be sent to the employer for review and input.

Step 4 Creation of first and second draft Physical Capacity Test (PCT):
After any necessary revisions of the JTA, the OT/PT creates the PCT, including the minimum standard for a passing result. This draft will be sent to the employer for review and input. (If necessary, a second draft and review/revise process may take place).

Step 5 Validation:
The Account Manager will facilitate scheduling of the validation which takes place at a Providence Occupational Medicine clinic.
Participants needed from employer:

- 2 incumbents who are familiar with the job and physically able to take the PCT without injury to themselves.
- 1 supervisor or person with decision making ability.

Validation may occur with only 2 employer participants as long as both are able to take the PCT safely and one of them has decision making ability. (This allows changes to be made during the validation and improves efficiency of the process).

Participants from Providence: OT/PT, Account Manager, Clinic Supervisor/Manager or MA (for training purposes), and the Account Executive (if available).

Step 6 Final Document:
The OT/PT will update the PCT to include any changes or modifications agreed upon during the validation. A copy of the final document will be provided to the employer by the Account Manager. Once the client has given final approval on the JTA/PCT the Account Manager will ensure the employer's account is updated to include the new JTA/PCT and documents are appropriately stored in the Occupational Medicine data base.

Step 7 Clinic Staff Training:
The Account Manager will work with the Clinic Supervisor/Manager to ensure clinic staff are trained on the new PCT in a timely manner. Once staff training is complete the Account Manager will notify the employer that the process is complete.

JTA/PCT Timeline

JTA/PCT development and *approximate* timeline:

OT/PT travel time is charged to the employer in the final invoice.

JTA/PCT rewrite: 4 pages or less: 2-4 hours (~1-2 weeks)
JTA/PCT rewrite: 5 pages or more: 4-6 hours (~2-4 weeks)
JTA/PCT new: 6-8 hours (~4-6 weeks)

Most JTA/PCT's can be created and completed for around $2,400.00 each. This is just an average cost. The total cost of the completed JTA/PCT is dependent upon travel time, the time spent observing, creating and validating the project.

Most JTA/PCT's take ~4-6 weeks from start to finish to complete. Could be longer depending on circumstances.

Post Offer Medical Examinations/Physical Capacity Test (PCT)

The examining provider reviews both the medical history that has been completed by the candidate and the appropriate job description based on the information that has been supplied by Clackamas County. After review, the provider performs a medical examination. In addition, the candidate may complete a physical capacity test that has been custom developed for jobs with PCT's. When all exams and ancillary services have been completed, the provider reviews the examination and makes a determination on the candidate's ability to perform the essential functions of the job. A report of the findings is then communicated to the appropriate contact at Clackamas County.

Custom Physical Capacity Test development process involves an estimated four to eight hours for the job task analysis and PCT development per job class. The Occupational Therapist visits the worksite to evaluate the job and observe employees performing the job. Physical demands are weighed and measured to develop a representative test for each job class.

Fitness for Duty / Return to Work Examinations

A Fitness for Duty (FFD) Evaluation is a focused evaluation, performed at the request of the employer. Triggers of a FFD exam can be observed behavior with objective evidence of a problem (e.g., excessive number in errors in job tasks, reduced productivity or frequent injuries or near-misses, other observed health problems on the job etc.).

A Return-to-Work (RTW) Evaluation is a focused evaluation, performed at the request of the employer if the employee is returning to work after an extended absence including work comp injury/illness.

The exam includes review of a medical history form, interview, and examination of a person currently employed by the requesting employer. (The employee may be off work, but a FFD is not performed in a "pre-hire" situation).

The purpose is to determine whether an employee can safely perform his/her essential job functions without endangering him or herself or others and whether or not any work restrictions may be necessary. The purpose is not to diagnose or treat medical/mental health conditions.

The employer will not be given information about any medical conditions identified. Providence Occupational Medicine is unable to fill out and sign ADA or FMLA paperwork. Providence Occupational Medicine does not perform psychological evaluations.

- For a FFD exam the employer must provide a "letter of concern" where it is clearly stated the reason(s) for the evaluation and the specific job functions in question or of concern/interest and the functional job description or job analysis.
    - Once the "letter of concern" for FFD or RTW authorization and job description/analysis is received at the clinic it will be reviewed by the clinic supervisor and/or medical provider to determine if the exam is within the scope of Occupational Medicine.
    - If it is determined that the exam is not within our scope of practice the clinic supervisor will contact the person requesting the exam, to explain why we are unable to perform the service.
- For a RTW exam an authorization form needs to be provided along with a functional job description or job analysis. If the employee has been released to work by his/her treating physician, that work release should be provided at time of exam to avoid potential delays

  in the exam process. (If there is no known treatment then the requirement for the work release does not apply). Additional records may be requested if they are needed to make a determination.
- DOT RTW/FFD is an exam to determine if a driver currently meets the FMCSA requirements to drive. An exam authorization from the employer is needed to schedule the appointment; the scope is limited to pass/fail under DOT requirements. If additional records are required, we will follow our normal exam process. A driver cannot be qualified if they are being treated for a current work injury, we recommend providing the work release at the time of the appointment to avoid delays in the exam process.

Further testing (e.g., Physical or Work Capacity Evaluation; Neurological tests, Radiological studies, etc.) may be necessary depending on the specific demands and safety risks of the job and health conditions suspected or identified. There will be additional expense involved if medical record review or additional testing is required.

The employer is ultimately responsible for making the decision whether or not to keep/return the employee to work, with or without accommodations, and they are obligated to follow FMLA, ADA, OSHA and other applicable rules/regulations when making their decisions. We do not fill out ADA/FMLA forms as these should be filled out by the employee's primary care/treating physician.

State and Federal Regulatory Examinations

The Providence Occupational Medicine clinics provide a variety of State and Federal regulatory exams such as those required by OSHA. Examples are respiratory exams, police exams, firefighter exams, DOT exams, DOE exams, medical surveillance exams and audiometric testing. Examinations are performed in accordance with the established standards. Protocols will be established to reflect the Clackamas County's individual needs.

Department of Transportation Examinations

The Providence Occupational Medicine providers have complete knowledge and understanding of the Commercial Driver Fitness Determination examination requirements. All of our providers can be found on the National Registry and meet all of the new DOT CME regulation requirements. The examination is completed using the newest long form with the updated Department of Transportation requirements and driver certificates. We provide DOT new hire exams, DOT recertification exams, and DOT fitness for duty exams. DOT qualifications if requested with post offer physicals are offered at a lower rate than performing the exam alone.

Department of Transportation (DOT) & Non-DOT Post Offer Drug Testing

Providence Occupational Medicine offers both DOT and non-DOT drug screen services for pre-placement as well as post-accident, random, reasonable suspicion and for cause reasons.

We have established our own account with a reputable drug testing laboratory which allows employers without an existing laboratory relationship to access our volume pricing and avoid complicated laboratory account set up. We use Alere/Escreen for our laboratory-based testing. We offer 11 different non-DOT lab-based drug test panels, and the DOT panel. The drugs in each non-DOT panel vary. Our drug panel list is available upon request.

Please note: Providence Occupational Medicine is not a Consortium/Third Party Administrator (C/TPA). We do not oversee/manage random DOT pools.

When using our house account, all drug screen results are sent to the Medical Review Officer (MRO). If the results are negative, the MRO will “rubberstamp” the results and report out. If positive, the MRO will contact the donor to discuss the positive, obtain prescription information and will contact the necessary pharmacies to verify prescriptions. If there are verifiable prescriptions, then the positive will become a negative. If there are no verifiable prescriptions, then the positive will stand. As marijuana (THC) is still illegal at the Federal level, any THC positives will remain as positive. THC results do not change because of decriminalization in certain states.

Typical turnaround for laboratory-based drug screens is around 2-3 days. It is possible for results come back next business day however, we do not guarantee it. The turnaround time can be longer than 3 days if the results are positive and the MRO is trying to reach the donor to discuss the positive(s).

Reporting of the drug screen results comes directly from the lab. They can send to a fax machine or send email notification to the primary person on the account, that a result is ready then you just log into the lab system to retrieve it.

All Providence Occupational Medicine collection site facilities adhere to DOT specifications and all DOT urine drug screen collection are performed in accordance with federal regulations. Non-DOT drug screen collections are also performed in accordance with federal regulations however Clackamas County may specify certain situations in which we are to deviate from the DOT standards (e.g., employers often do not want to perform observed collections for non-DOT tests and will opt for a monitored or standard collection instead).

As with our collection-only services, DOT and non-DOT drug tests are available on a walk-in basis at all our occupational medicine clinics.

DOT & Non-DOT Breath Alcohol Test (BAT)
Breath alcohol testing is available at all occupational medicine clinics on a walk-in basis. We have certified breath alcohol technicians on staff within our clinics all of whom are DOT certified in accordance with the U.S. Department of Transportation Testing Procedures 43 CFR Part 40.

Respirator Examinations

Providence has created a respiratory protection program in accordance with OSHA 1910.134. Annual respirator exams are not required by OSHA guidelines, but a periodic or exit evaluation can be elected by the Clackamas County for those employees who are required to wear respirators.

We can provide review of the OSHA respirator questionnaire as a stand-alone service to determine physical qualification to wear a respirator, with a post offer exam or we can provide the exam as a stand-alone service. We can provide respirator fit testing at the County's request with or without an exam. Fit testing is available at all 5 Portland area clinics depending on your make/model of the masks used. Respirator exams, spirometry and fit testing can be performed onsite for groups of 10 or more. Pricing varies and additional charges apply.

DPSST F-2T Exams

Telecommunicators and Emergency Medical Dispatchers are also conducted based on the Department of Public Safety Standards and Training (DPSST) medical exam (form F-2T). This exam for Clackamas County would include a physical exam with history review, audiogram and necessary vision screening. Optional services such as drug screening could be added to this exam.

Audiometry Testing

We are available to perform baseline audiograms or audiograms with hearing conservation reporting. We can perform baseline audiograms, annual audiograms and threshold shift retests to determine if the threshold shift is work related and recordable. This information can be sent to

the hearing conservation contractor and/or the appropriate person with the County. Please note: the Newberg clinic does not offer audiogram services.

Immunizations / Vaccine Assessments

Vaccination offerings vary by clinic. Some of what we offer are TB screenings, as well as QuantiFERON Gold, MMR vaccinations, Varicella, Hepatitis B and influenza (when seasonally available), Tetanus and TDAP.

Vaccine Assessments are available when the candidate/employee is unsure of where they are with their vaccine history. They would schedule an appointment, bring with them all of their vaccine records for the provider to review and determine next course of action with the vaccines (e.g., either titer testing or boosters).

Onsite immunizations and vaccine assessments can be performed onsite for groups of 10 or more. Pricing varies and additional charges apply.

Clockwise MD

Providence Occupational Medicine utilizes a program called Clockwise MD, which allows the candidate/employee to *"get their place in line"* for drug/alcohol testing as well as audiograms, immunizations/vaccinations, and respirator fit testing. This program is not for scheduled exams that require a medical provider.

Clockwise MD allows a person to "get their place in line" ahead of people that just walk-in for services. The candidate/employee can Google the clinic that they want to go to (links below):

Providence Occupational Medicine-The Plaza | Providence Oregon
Providence Occupational Medicine | Bridgeport, Oregon | Providence Oregon
Providence Occupational Medicine | Clackamas, Oregon | Providence Oregon
Providence Occupational Medicine - Mill Plain | Vancouver, Washington | Providence Oregon
Providence Occupational Medicine - Tanasbourne | Hillsboro, Oregon | Providence Oregon
Providence Occupational Medicine | Newberg, Oregon | Providence Oregon

On the landing page is a widget that shows the current wait time for that clinic for walk-in services. Clockwise MD provides an estimated wait based on how many people are in the clinic at the time the individual wants to come in. The wait time will update as the line changes.

Just click on Reserve My Spot, fill in some information and the system well text the individual when it is time to head into the clinic. Then they just check in at the kiosk upon arrival. It isn't mandatory that it be used but it is highly effective for keeping the worker at work and working vs. sitting in the waiting room waiting to be seen.

Project Approach and Understanding

Knowledge of Occupational Health Related Regulations

Our providers have complete and current knowledge of OSHA regulations and standards, National Fire Protection Association guidelines, Department of Public Safety Standards and Training and Department of Transportation regulations among others. They stay current with standards and practices through State and Federal publications and various continuing medical education events. If new testing criteria are established for Occupational Medicine regulations, we will present it to the County.

Work Plan

A scheduler will set up appointments for services generally within 24 to 48 hours of scheduling based on established protocols. Team members will be assigned to conduct the exams in a timely manner. We work in conjunction with Clackamas County and review work processes to ensure the best practices are followed to meet your occupational medicine needs staying in compliance with current regulations.

We have developed an efficient yet comprehensive post offer evaluation. The physical examination which includes detailed work and medical history questionnaires that are reviewed by the medical provider and discusses with the examinee, as well as a comprehensive physical examination. Each examination begins with standard components which are expanded by the medical provider as necessary, depending on the examinee's medical history and the physical nature of the job in question.

In general, this is our process:

- When an appointment is desired, a representative from Clackamas County or the candidate/employee (hereafter referred to as “examinee”) contacts our Central Scheduling Desk to arrange an appointment at a desired clinic location.
- Upon arrival at our clinic, the examinee is registered by our front desk staff, including completion of any required forms.
- After registration, the examinee is then escorted to our back office where any necessary ancillary services are performed by our certified Medical Assistants or Technicians (e.g., height, weight, blood pressure, vision screens, hearing tests, lung function tests, drug screenings etc.).
- After the ancillary services are complete and recorded, the examinee is escorted to an examination room where the remainder of the services are performed by a qualified medical provider.
- If the medical exam requires a physical capacity test (PCT), then after the medical exam with the provider, the MA will then take the examinee to the PCT room and proctor that portion of the exam. The findings are then presented back to the medical provider for completion of the medical report. The PCT is always performed after the medical exam with the provider who gives clearance for the MA to proceed or not.
- Upon completion of the appointment our front desk staff will assist the examinee in “checking out”.

Following completion of the post offer examination, we then will provide a one-page report to Clackamas County which indicates the examinee is either cleared to perform the job without restriction/accommodations, identifies limitations/accommodation, or that further evaluation is necessary, such as additional testing, or review of requested medical records. DPSST F2T exam results will be reported out in its entirety on the F-2T form or the F2Ta if instructed.

No protected health information is included in the report provided to Clackamas County. Examinees are not provided a copy of the report, nor given information about the results unless special instructions to do so are provided by Clackamas County.

The post offer evaluation is usually completed in one visit. Occasionally, based on a specific examinee’s history, additional medical information may be needed. Our staff will obtain the necessary release from the examinee and request records. The records are automatically reviewed within one to two business days of receipt and a final report of findings issued. Once the examination has been completed, the records are processed, and appropriate reports are sent to the identified Clackamas County contact. The reporting process is completed within 24 to 48 hours of the examination or when lab and ancillary results are available.

Our new electronic medical record system (SYSTOC) will allow authorized County employees 24/7 access to our system, which will allow you to pull your own medical exam results as well as invoices. The system will send an email when results are ready, then just log into the system to retrieve them.

Our email settings in SYSTOC use an SSL (Secure Sockets Layer) setting on outgoing emails which encrypts the email for sending off of the secure site. It is encrypted but does not require the extra security step of setting up an individual log in as the message does not stay stored on a server. There is a contract that Clackamas County would need to sign prior to getting access

to the portal. Advanced set up and a brief training are necessary before gaining access to the system.

Providers and staff are available to answer questions that Clackamas County may have regarding the examinations. Protocols can be adjusted at Clackamas County's request based on job classification or job duty changes or updates in regulatory requirements.

Client References

C-Tran
Clark County Public Transit
Contact: Brenda Hamilton
Title: HR Programs Manager
Address: 10600 NE 51st Circle Vancouver, WA 98682
Phone: 360.906.7457
Email: brenda.hamilton@c-tran.org
Type of work performed: Audiograms, DOT medical exams, Expanded Physical, Fit for Duty/Return to Work exams, Immunizations/Vaccinations, Respirator services, Prescription & OTC Medication Consults, DOT drug/alcohol testing, and Work Comp Injury Care

Tualatin Valley Water District
Contact: Mike Jacobs
Title: Health and Safety
Address: 1850 SW 170th Beaverton, OR 97006
Phone: 503- 848-3048
Email: mikej@tvwd.org
Type of work performed: DOT Exams, Pre-placement Exams, Physical Capacities Testing, Respirator Exams, Audiograms, and Drug/Alcohol Screening

Metro
Contact: Mike Amodeo
Title: Environmental Health & Safety
Address: 600 NE Grand Ave Portland, OR 97232
Phone: 503-797-1937
Email: mike.amodeo@oregonmetro.gov
Type of work performed: Pre-placement, Respirator, Fit for Duty Exams, DOT drug/alcohol screen collections and employment drug testing, Physical Capacity Tests, Physical Capacity Test Development and Workers Compensation Injury Care

SERVICES	Service Offered (X if Yes)	FEE(S)
Job Analyses/Physical Capacity Test Creations:	x	$300.00 per hour
Identify and document job tasks and physical demands	x	Included
Develop tests to measure	x	Included
Validate tests	x	Included
Implement tests	x	Included
Pre-Placement Exams to include:	x	$85.00
Vital signs, height, weight, vision (Snellen) and body systems with emphasis on neuromuscular and orthopedic systems	x	Included
Comprehensive medical history review	x	Included
Audiometry (hearing) exams - baseline	x	$25.00
Functional Capacity Evaluations to include:	x	
Heavy physical demands capacity testing	x	$85.00
Light physical demands capacity testing	x	$63.00
Return to Work Exams	x	$125.00
Fitness for Duty Exams	x	$150.00
DOT (Dept. of Transportation) to include:	x	
Physical exam per DOT regulations	x	$95.00
Drug analysis screening with chain of evidence procedures (DOT Test - all inconclusive (includes collection/lab test/MRO)	x	$58.00
Medical review services for positive DOT drug analysis screening	x	Included
Breath alcohol analysis screening w/chain of evidence procedures	x	$30.00
DOT qualification - this is a reduced fee if adding DOT medical certification to a pre-placement medical exam	x	$25.00
NON-DOT Drug and Alcohol to include:	x	
Drug analysis screening with chain of evidence prodecures (Non-DOT Test - all inconclusive (includes collection/lab test only)	x	$37.00
Medical review services for positive non-DOT drug analysis screening	x	Included
Breath alcohol analysis screening with chain of evidence procedures	x	$30.00
Non-DOT drug screen collections (CCSO only)	x	$19.00
Non-DOT UDS observation fee	x	$20.00
NIOSH Approved Respiratory Testing:	x	
Respirator physical (includes respirator questionnaire)	x	$65.00
Respirator physical (includes respirator questionnaire) onsite	x	$75.00
Pulmonary function test (spirometry)	x	$36.00
Pulmonary function test (spirometry) onsite	x	$40.00
Respirator questionniare processing (if mailed in)	x	$25.00
Respirator fit testing (examinee supplies the mask)	x	$40.00 per mask type
Respirator fit testing onsite (examinee supplies the mask)	x	$47.00 per mask type
Respirator qualification - this should be a reduced fee if adding respirator clearance to a medical exam	x	$25.00
DPSST F2T Exams to include:	x	$85.00
Vital signs, height, weight, vision (Snellen) and body systems with emphasis on neuromuscular and orthopedic systems	x	Included

SERVICES	Service Offered (X if Yes)	FEE(S)
Audiogram	x	$25.00
Ishihara color test	x	$10.00
Titmus vision test	x	$25.00
Additional Services (as needed/requested):		
Vaccination Assessments	x	$50.00
Hepatitis A vaccination series (2 shot series)	x	$88.00 ea
Hepatitis A vaccination series (2 shot series) onsite	x	$95.00 ea
Blood draw and lab test for Hepatitis A		there is no blood draw and titer test for Hepatitis A
Hepatitis B vaccination series (3 shot series)	x	$61.00 ea
Hepatitis B vaccination series (3 shot series) onsite	x	$89.00
Blood draw and lab test for Hepatitis B	x	$47.00
Blood draw and lab test for Hepatitis B onsite	x	$47.00
Hepatitis C Blood draw and lab test	x	$62.00
HIV Antibody Test 4th Generation - Source Testing	x	$55.00
Hepatitis B Surface Antigen - Source Testing	x	$45.00
Hepatitis A/B Vaccine HEPA-HEPB Adult IM (3 shot series)	x	$145.00 ea
Tetanus vaccine TDAP - includes administration	x	$87.00
Tuberculosis skin test (PPD)	x	$29.00
Tuberculosis skin test (PPD) onsite	x	$37.00
TB test review/X-Ray order by MD		$ -
Chest X-Ray 1-view	x	$95.00
Chest X-Ray 2-view	x	$125.00
Blood Lead w/ZPP	x	$57.00
Asbestos exam	x	$100.00
B-Reader	x	$70.00
Maritime exam	x	$95.00
Flu - Annually	x	$27.00
MMR - if born 1957 or later		$ -
Measles/Mumps/Rubella Virus Live SubQ	x	$85.00
Measles/Mumps/Rubella Virus Live SubQ onsite	x	$95.00
Rubeola Antibody	x	$56.00
Rubeola Antibody onsite	x	$56.00
Rubella Antibody	x	$64.00
Rubella Antibody onsite	x	$64.00
Mumps Antibody	x	$59.00
Mumps Antibody onsite	x	$59.00
Varicella Virus Vaccine Live SubQ (2 shot series)	x	$136.00 ea
Varicella Virus Vaccine Live SubQ (2 shot series) onsite	x	$136.00 ea
Varicella Zoster Antibody	x	$62.00
Varicella Zoster Antibody onsite	x	$62.00
Tdap - Booster every 10 years		$ -
Tdap vaccine	x	$87.00
Venipuncture	x	$15.00
Quantiferon Gold	x	$49.00
Physician Lab Review	x	$25.00
Physician Consult	x	$55.00
On-Site Services - Professional Fee - MD onsite per hour	x	$300.00

SERVICES	Service Offered (X if Yes)	FEE(S)
On-Site Services - Professional Fee - NP onsite per hour	x	$90.00
On-Site Services - Professional Fee - RN onsite per hour	x	$76.00
On-Site Services - Professional Fee - MA onsite per hour	x	$45.00
On-Site Each Additional Hour	x	$45.00
Mileage Per Mile	x	$1.00
Other charges that may apply:		
Record review brief		$25.00
Record review extended		$50.00
Exam follow-up brief		$55.00
No show fee		Price is equalvalent to the cost of the exam

EXHIBIT D
DATA ACCESS ORGANIZATION TO ORGANIZATION AGREEMENT
(Electronic Access to Records)

Data Access Organization to Organization Agreement

Providence Disclosure of Employee Information via Electronic Access

Providence Access Support Team for Reporting Issues or Requesting Assistance	Michelle Varner, SYSTOC IS Liaison
Email Address	michelle.varner@providence.org

Providence Business Liaison/Primary Contact	Laura Cook, Account Manager Occupational Medicine
Email Address	laura.cook@providence.org
Fax Number	971-712-2184

Disclosing Employee Data to the listed Organization ("Client")	Clackamas County
Organization Location Name (if different than above)	Clackamas County
Street Address	2051 Kaen Rd
City	Oregon City
State, Zip	Oregon, 97045
Phone Number	503-655-8459

Organization Business Contact - Primary	Trish Bafus
Email Address	TrishaBaf@clackamas.us
Phone Number	503.742.5482
Organization Business Contact – Secondary	Eric Machado
Email Address	EMachado@clackamas.us
Phone Number	503.655.8576

The purpose of this Data Access (Org2Org) Agreement is to establish an understanding between Providence and Clackamas County [Client] regarding the expectations of the parties which will govern the relationship between Providence and Client pursuant to which Providence will grant Access to certain electronic information to Client.

RECITALS

WHEREAS, the parties believe that granting Client electronic Access to information systems owned or operated by Providence for Client's Users (as defined in Section II) to have timely and accurate employee health information from Providence's system for the sole purpose of viewing data for its employees as permitted by law.

WHEREAS, some or all information to be disclosed is required by law to be protected against unauthorized use, disclosure, modification, or loss. To comply with applicable legal requirements for the protection of information, the parties agree to the terms herein.

Providence

Data Access Organization to Organization Agreement

Providence Disclosure of Employee Information via Electronic Access

AGREEMENT

1. Purpose

Providence agrees to provide electronic access to electronic information systems owned or operated by Providence ("Systems") to authorized Users (as defined in Section II). Client shall ensure that all use of Systems shall be exclusively for viewing of employee data as permitted by law. Providence makes the Systems available to Users to provide view-only access to applicable Pure OHS data, such as patient-specific injury, treatment, and drug-screen information as permitted by law. Access to the Systems is intended solely for these purposes. Any other use or any attempt to use the Systems for commercial purposes or other purposes is strictly prohibited. Client understands that electronic access to the Systems is a privilege offered at the sole discretion of Providence. **Client understands and acknowledges that Providence may withhold or terminate User Access at any time for any reason**. Providence makes no implied or explicit commitment that the connection will work at any time in the future, due to unforeseen system or network downtimes.

2. Definitions

"Workforce" means Client's employees, contractors, volunteers, trainees, agents, and other persons who perform work for or on behalf of Client.

"User" means an individual Client Workforce member.

"Access" means the permissions granted to the User is based on their need to know and job responsibilities.

3. Term

This Agreement shall be effective as of the date that the Client signs, and shall continue subject to the termination provisions hereof. This Agreement may be terminated without penalty by either party at any time or will automatically terminate if no Users have Access.

4. Costs and Expenses

Each party agrees to be individually responsible for the costs and expense of maintaining appropriate security and privacy controls relating to their information system(s). Client is responsible for the cost of the appropriate hardware and software to access Providence systems or data. This includes, but is not limited to, initial purchase, upgrade, and ongoing support.

5. Relationship of Parties

This Agreement will not be construed to create a partnership, joint venture, or employment relationship among the parties or their employees or agents.

6. No Discrimination.

The Client is further expressly prohibited from using the Systems in any manner that discriminates against persons on the basis of their race, color, religion, age, national origin, ancestry, gender, sexual orientation, disability, veteran status, financial status, or ability to pay, or participation in government- funded health care programs.

Data Access Organization to Organization Agreement

Providence Disclosure of Employee Information via Electronic Access

7. Legal Compliance.

The parties will comply with all federal and/or state laws, ordinances and regulations with respect to its performance under this Agreement. The parties agree that nothing in this Agreement constitutes, or is intended to constitute, an inducement by Providence for Client to refer patients to Providence facilities or personnel, or to recommend or arrange for patients to receive items or services from Providence facilities or personnel. The parties agree to comply with all applicable laws and regulations relative to this Agreement, including without limitation Federal Anti- Kickback Statute (42 U.S.C. Sec. 1320a-7(b) (the "Anti-Kickback Statute") and the Physician Self-Referral Law (42 U.S.C. Sec. 1395nn) (also referred to as the "Stark Law"). The parties agree that the Client's access to the Systems does not constitute the provision of remuneration or any other thing of value to the Client, and that the Client has no legally cognizable interest in this Agreement or continued access to the Systems.

8. Data Ownership

Access to Systems or data does not in any way create an ownership right in Systems or data to Client or User. The data available on the Systems remains the property of its owner. Once the data on the Systems has been downloaded, printed or otherwise reproduced by Users for payment or other lawful purpose, the data shall be the responsibility of Client and shall be treated according to Client's policies. Data that is contained within the Systems will be available for the support of patients in compliance with HIPAA, ARRA/HITECH, state and federal privacy standards. Providence does not warrant or represent the truth, accuracy or completeness of any information provided to the Client pursuant to this Agreement.

9. Security and Privacy Obligations

A. Client shall assign the above Client Business Contact/Authority as responsible for managing the authorized Users on behalf of Client.

B. Users may only access information contained in the Systems for the purpose of viewing Pure OHS data, such as patient-specific injury, treatment, and drug-screen information, or other lawful reason.

C. Client agrees to reasonably assist Providence in enforcing appropriate security and privacy controls governing the Systems and the information contained therein to which Users are granted Access as described herein.

D. Users shall not make any change to any information in the Systems.

E. Client shall ensure all its Users comply with applicable Providence policies. Access will not be granted until each User completes the required forms.

F. Access to Systems will be granted according to Providence policies and procedures, and shall comply with applicable federal and state laws, including but not limited to HIPAA or ARRA/HITECH. Each User shall be responsible for his/her login and password and shall not share his/her login and password with anyone else. Client will maintain firewall protection on all Internet connections for computers or devices located at Client's locations.

G. Client will ensure the use of updated versions of commercially reasonable anti-virus protection on all computers or devices that are used to access Systems. Client agrees to keep its computers and devices updated with commercially reasonable operating system patches and to use and maintain firewall protection. Client agrees that when

and while remotely connecting to Systems, it is subject to Providence rules and policies governing privacy and security as provided by Providence.

H. Providence reserves the right to monitor, log, review, and/or audit all data access and use of Systems. Providence, in its sole determination, may act against any unauthorized use or access to Systems, including but not limited to termination of Client or User Access, or immediate termination of this Agreement.

I. **Client agrees to notify the above identified Providence Access Support Team the same business day** if a User has experienced a separation/termination from Client so that account Access may be terminated immediately.

J. **Client agrees to notify the above identified Providence Access Support Team the same business day** for any changes in Access, but in no event will notice be longer than five (5) days after any changes in roles or job function of a User.

K. **Client agrees to notify the above identified Providence Access Support Team the same business day** if there is any change of personnel for the above designated Client Business Contact/Authority, but in no event will notice be longer than five (5) days after any changes in roles or job function.

L. Client will direct Users to contact the above identified Providence Access Support Team for issues specifically related to failure to access or issues with the application to which they have been granted Access. Client is responsible for the maintenance and repairs to their own devices, computer systems or network connections, including the connection to Providence.

M. Client will respond to Providence periodic User account reviews within five (5) business days.

N. Providence may disable User accounts that are inactive for 90 days or longer without notice to Client. In these situations, Client shall contact the above identified Providence Business Liaison/Primary Contact to request that Access be reactivated.

O. Client will ensure that Users do not share login and password information with other individuals. Client will ensure that Users do not permit login and password to be automatically saved on any computers or devices. Sharing of login and/or password information or permitting such to be automatically saved may result in termination of Access.

P. Users will only be granted Access if they are a member of Client's Workforce and the forms required by Providence have been fully executed.

Q. Client will ensure Users only access minimum necessary information for which they have a legitimate reason and are authorized by law to access.

R. **Client shall notify Providence within twenty-four business hours** of having such knowledge of any unauthorized Access.

10. Compliance with Laws and Governing Law

The sole jurisdiction for any legal proceedings under this Agreement shall be Oregon.

Providence

Data Access Organization to Organization Agreement

Providence Disclosure of Employee Information via Electronic Access

11. Confidentiality

The parties agree that all information communicated to it with respect to the Pure OHS data is confidential and agree not to disclose any such confidential information to any other person unless specifically authorized in writing by the other party or to the extent authorized under applicable law. The parties shall use their best efforts to prevent any disclosure of any confidential information to any third party and shall instruct all personnel under its management and control to maintain the confidentiality of the data.

12. Indemnification

Each of the parties agrees to be liable for its own conduct and that of its employees and agents, while acting within the course and scope of their employment or engagement, and to indemnify the other party against all losses therefore arising from or in connection with this Agreement. If loss or damage results from the conduct of more than one party, each party agrees to be responsible for its own proportionate share of the claimant's total damages under the laws of the State of Oregon. Neither party will be considered the agent of the other nor neither party assumes any responsibility to the other party for the consequences of any act or omission of any person, firm, or corporation not a party to this Agreement. Client's indemnification obligations under this Section 12 are subject to the limits of the Oregon Constitution and the Oregon Tort Claim Act.

13. Entire Agreement, Assignment, and Amendment

This Agreement constitutes the entire agreement between the parties about Client's Access to Providence's Systems, and supersedes all prior oral or written agreements, commitments, or understandings concerning the matters provided for herein. This Agreement may not be assigned without the written consent of the other party. This Agreement may be modified only in writing and executed by the parties. All rights are granted to Client are expressed herein; no other rights are granted as part of this Agreement.

14. Severability

Should any part or portion of this Agreement be found invalid, the balance of the provisions shall remain unaffected and shall be enforceable.

15. Non-Waiver

Neither the waiver by Providence of a breach of or a default under any of the provisions of this Agreement, nor the failure of Providence, on one or more occasions, to enforce any of the provisions of this Agreement or to exercise any right or privilege hereunder, will thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any of such provisions, rights or privileges hereunder.

Data Access Organization to Organization Agreement

Providence Disclosure of Employee Information via Electronic Access

16. Signatory Authority

By signing below, the parties agree to the terms of this Agreement and represent they have the authority to bind the entity on behalf of which it is signing. For purposes of this Agreement, facsimile or electronic copies of signatures shall be deemed to be original signatures.

Providence St. Joseph Health Organization Initiating Agreement		**Client**	
Providence:	Providence Occupational Medicine	Client Legal Name:	Clackamas County
Printed Name:	Aimee L. Tinkle	Printed Name:	
Title:	Senior Manager	Title:	
Signature:	Aimee L Tinkle	Signature:	
Date:	October 28, 2021	Date:	

Please scan/email or fax back to the Account Manager listed on page 1.

NORTH CLACKAMAS PARKS AND RECREATION DISTRICT
Development Services Building
150 Beavercreek Road, Oregon City, OR 97045

Michael Bork, NCPRD Director

11/24/2021

Board of County Commissioners
Clackamas County
Board of North Clackamas Parks and Recreation District

Members of the Board:

**Approval of an Intergovernmental Agreement Between:
The City of Milwaukie and North Clackamas Parks and Recreation District
for Grant Administration, Construction, and Operation of Phase III of Milwaukie Bay Park**

Purpose/Outcome	Establish roles and responsibilities between the City and NCPRD for grant administration, construction, and operation of Phase III of Milwaukie Bay Park.
Dollar Amount and Fiscal Impact	$32,000 annually estimated from NCPRD's operating budget for maintenance of new improvements after the park is constructed. No County General Funds are involved. (Details related to funding for indirect and direct costs of construction are under separate IGA.)
Funding Source	NCPRD General Fund
Duration	In effect until terminated or superseded.
Previous Board Action/Review	• June 28, 2018 Business Meeting: Board approved professional services contract between NCPRD and 2.ink Studio for Milwaukie Bay Park Final Design Services. • 2019-2021 Board approvals: grant submittals, grant agreement, IGA with City of Milwaukie to transfer City funds to NCPRD for project, contract for Owner's Representative Services, and authorization to obtain a Construction Manager/General Contractor. • 2017-2021 Board Updates (5)
Strategic Plan Alignment	**1. *How does this item align with your department's Strategic Business Plan goals?*** • Aligns with the NCPRD Asset Development Strategic result of completing 33% of NCPRD project phases in the annual Capital Improvement Plan • Supports the purpose of the Asset Development program by providing planning and development services to NCPRD residents • Supports the purpose of NCPRD overall by providing access to parks, natural areas, trails, recreation services and facilities ***2. How does this item align with the County's Performance Clackamas goals?***

	• *Honor, Utilize, Promote, and Invest in our Natural Resources* by creating increased tree canopy, increased natural areas, better on-site stormwater utilization, increased floodplain resilience. • *Build a Strong Infrastructure* through improved recreation infrastructure, active transportation corridor and safe access public transportation, and improved stormwater management. • *Build Public Trust through Good Government* by design with inclusive engagement and partnership building to leverage funding. • *Grow a Vibrant Economy* by increasing visitation in the area and attracting more people to the surrounding retail and commercial areas within Clackamas County.
Counsel Review	1. 10/7/2021 2. JM
Procurement Review	1. No
Contact Person	Michael Bork, NCPRD Director, x4421 Heather Koch, NCPRD Acting Planning & Development Manager, x4358

SUMMARY

The Intergovernmental Agreement (IGA) establishes the roles and responsibilities between the City of Milwaukie (City) and the North Clackamas Parks and Recreation District (NCPRD) for grant administration, construction and operation of Phase III of Milwaukie Bay Park. The agreement is constructed to be similar to the most recent park development project agreement with the City for Wichita Park (2017). A termination clause protects both parties by ensuring that, if terminated, the terminating party would pay a prorated portion of the other party's development costs. Members of the NCPRD Board, City Council and respective legal staff and administrators negotiated this agreement.

On November 2, 2021, the City Council introduced and adopted Council Resolution 56-2021 to authorize the City Manager to execute the agreement.

An upcoming update to the 2020 Funding IGA between the City and NCPRD for the Milwaukie Bay Park Project will update funding commitments needed to construct the project. The current estimated Total Project Cost is $9.6 million including construction costs, design costs and indirect costs.

BACKGROUND

NCPRD partnered with the City of Milwaukie in 2018-19 to develop a final design to complete Milwaukie Bay Park as a District-wide recreational waterfront. The design transforms 3.6 acres of underutilized and predominantly undeveloped land into places to play, rest and gather. Key features include: an amphitheater, nature play area, interactive water feature, plaza with picnic terrace, a permanent alignment for the regional Trolley Trail, pathways, natural areas, public art and restrooms. NCPRD engaged a broad and diverse range of over 1,300 community members in the District during the design phase, advanced a funding strategy to leverage local, regional, state and other funds, and developed a process to build a preconstruction and construction services team in FY20-21.

The park is identified as a high priority need in the 2004 NCPRD Master Plan and 2007 NCPRD Parks and Recreation System Development Charges (SDC) Update Methodology Report and Capital Improvement Plan. The City owns the park and NCPRD plans for, develops and manages the City's parks under a Cooperative IGA. The Cooperative IGA was created as part of the formation of the District in 1990, and last amended in 2020 to reflect the adoption of new bylaws for the District Advisory Committee (DAC).

RECOMMENDATION:
Staff respectfully recommends that the Board of County Commissioners, acting as the NCPRD Board of Directors, approve this Intergovernmental Agreement Between: The City of Milwaukie and North Clackamas Parks and Recreation District for Grant Administration, Construction, and Operation of Phase III of Milwaukie Bay Park.

ATTACHMENTS:

1. Intergovernmental Agreement Between: The City of Milwaukie and North Clackamas Parks and Recreation District for Grant Administration, Construction, and Operation of Phase III of Milwaukie Bay Park
2. Council Resolution 56-2021

Respectfully submitted,

Michael Bork, Director
North Clackamas Parks and Recreation District

INTERGOVERNMENTAL AGREEMENT BETWEEN:
THE CITY OF MILWAUKIE AND
THE NORTH CLACKAMAS PARKS AND RECREATION DISTRICT
FOR GRANT ADMINSTRATION, CONSTRUCTION, AND OPERATION OF PHASE III OF MILWAUKIE BAY PARK

THIS AGREEMENT (this "Agreement") is entered into and between North Clackamas Parks and Recreation District ("NCPRD" or the "District"), a county service district established pursuant to ORS Chapter 451, and the City of Milwaukie ("City"), an Oregon municipal corporation (collectively, the "Parties" and individually "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.

This Agreement establishes roles and responsibilities between the City and NCPRD for funding, grant administration, and construction of Phase III of Milwaukie Bay Park (the "Project"), which is owned by the City and is intended to be operated and maintained by NCPRD.

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 remain in effect until terminated or superseded.
2. **Grant Management.** NCPRD and City agree to the following Grant responsibilities under this Agreement:

   A. **Grant Performance**. The District shall have primary responsibility for performance and completion of the Project, as it is described in the Oregon Community Paths Program and the Metro Local Share Grant Agreements. This includes, but is not limited to, project design, contractor selection and procurement, project management, compliance with all applicable laws and regulations, and payment pursuant to the Grant.

   B. **Grant Administration**. The District shall administer and comply with all conditions and requirements set forth by the Grant awards to District. This includes, but is not limited to, requests for reimbursement, progress reports, final reports, inspection reports, completed site plan, project boundary map, project appraisals, digital images of the completed project, and representations and warranties. The District shall send copies of all grant deliverables and correspondence to the City.

   C. **Recovery of Funds**. Any funds disbursed to the District under the Grant that are expended in violation or contravention of one or more of the provisions of the Grant or that remain unexpended on the earlier of termination or expiration of this Agreement must be returned to the Grantor by the District.

D. **Responsibility for Grant Funds**. The District shall assume sole liability for City or District breach of the Grant. Upon City or District's breach of conditions that requires State to return funds to the federal government, hold harmless and indemnify State for an amount equal to the funds received under the Grant; or if legal limitations apply to the indemnification ability of the Grantees of Grant Funds, the indemnification amount shall be the maximum amount of funds available for expenditure, including any available contingency funds or other available non-appropriated funds, up to the amount received under the Grant.

E. **Records Maintenance and Access**. The District shall make and retain proper and complete books of record and account and maintain all fiscal records related to the Grant and the Project in accordance with all applicable generally accepted accounting principles, generally accepted governmental auditing standards and state minimum standards for audits of municipal corporations as identified in Exhibit A. The District shall send copies of all records and expenditures to the City.

F. **Audit Requirements**. The District shall adhere to all terms and conditions regarding auditing requirements set forth by the Grant.

3. **Project Management.** The District and City agree to the following responsibilities under this Agreement:

A. Permits required for the initiation of construction will be secured by The District by March 31, 2024, and all construction must be completed by December 31, 2024, or such other dates as mutually agreed by the Parties.

B. City shall allow District to construct the park and offsite improvements on City property.

C. City shall delegate authority to District to act as the lead on development and construction.

D. District shall plan, design, engineer, and construct park improvements to District and City standards, and comply with conditions and requirements set forth by the Grants.

E. District shall develop construction plans, specifications, and estimates for park facilities, fixtures, open space, and offsite improvements in accordance with District procurement policies.

F. District shall advertise, bid, and award a contract for construction plans and specifications for park facilities, fixtures, open space, and offsite improvements in compliance with District procurement policies and State of Oregon public works contracting laws.

G. District shall manage and administer contractor and subcontractor bonds, licenses, insurances and certified payrolls in compliance with District procurement policies and State of Oregon public works contracting laws.

H. District shall coordinate relocation and installation of utilities with existing utility providers.

I. District shall coordinate community outreach with City during design and construction, including quarterly project updates to Milwaukie City Council, Milwaukie Parks and Recreation Board, and District Advisory Committee.

J. District shall provide City with as-built construction plans upon completion of project.

4. **Other Terms and Conditions**. District and City agree to the following responsibilities under this Agreement:

A. City shall retain ownership of park, offsite infrastructure and all other improvements that are not moveable and integral to the built out environment following completion of construction. For example, concrete pads, paths and walkways, sidewalk and curb improvements, striping, restroom facilities, shade structures, grading and scarifying of soils, imported fill material, trees, shrubs, grasses, and other landscaping materials .

B. District shall retain ownership of fixtures which are easily moveable and are not part of the permanent built out environment following completion of construction (i.e. picnic tables, signage, and waste receptacles) except for any portion of playground equipment paid for by the City or associated non-profit or Neighborhood District Association.

C. The District shall operate and maintain Milwaukie Bay Park as a High Maintenance Area as defined in the Master IGA between District and City. For any period of necessary construction or maintenance occurring at the park, portions or the entire park, may be closed consistent with District policy, practice, contract, ordinance, rule or law.

D. The District shall be responsible for scheduling of Milwaukie Bay Park programs with priority for District and City Events and activities. The District will manage and coordinate all District-led events and activities and District special use permits, including collection of appropriate fees.

E. The District shall offer structured recreational and community opportunities for youth and adults at Milwaukie Bay Park four days a week during the summer (mid-June – August), and as available the rest of the year. Programming shall reflect community interests, and be offered at times that meet attendance minimums. Programming may be impacted and reduced due to access, weather, conflicting events or health mandates.

5. **Termination**.

   A. Either NCPRD or the City 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 twenty-one (21) 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 twenty-one (21) day period, this provision shall be complied with if the breaching Party begins correction of the default within the twenty-one (21) 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.

   B. NCPRD may terminate this Agreement without penalty or obligation to the City in the event NCPRD fails to receive expenditure authority, grant awards, or other funding sufficient to allow NCPRD, in the exercise of its reasonable administrative discretion, to continue to perform under this Agreement, or if federal or state laws, regulations or guidelines are modified or interpreted in such a way that either the Project under this Agreement is prohibited or NCPRD is prohibited from paying for such work from the planned funding sources.

   C. Unless otherwise provided in this Agreement, a defaulting party shall be treated as if that party terminated this Agreement.

   D. The District or City's "Development Costs" for the construction for Phase III of Milwaukie Bay Park shall include all costs incurred, funds contributed, work performed, consultants hired, debt incurred, if as a result of termination of this agreement penalties accrued through non-performance, and any other costs or obligations incurred.

   E. Prorated Development Costs and funds contributed by a party shall be the amount of money that represents that percentage of the Development Costs and funds contributed based upon the 25 year useful life of the park improvements. For example if the contract were to terminate after five years 80% of the useful life of the improvements would be remaining. The terminating party would pay 80% of the other party's development costs in that example.

   F. Should a party terminate the agreement and after termination the City assumes operation and maintenance of the park and does not operate Milwaukie Bay Park with access for all NCPRD residents on the same terms (equal use rights for district and city residents) for a period of 25 years from park completion City shall pay the prorated Development Costs of NCPRD, and return funds to any entity granting funds for the Project consistent with the grant agreement.

   G. Should the City be withdrawn from NCPRD, City will be deemed to have terminated the Agreement.

6. **Indemnification**.

A. Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the District agrees to indemnify, save harmless and defend the City, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the District or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the District has a right to control.

Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the City agrees to indemnify, save harmless and defend the District, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the City or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the City has a right to control.

7. **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.

Milwaukie:
City Liaison
Peter Passarelli
10722 SE Main Street
Milwaukie, Oregon 97222
Email: passarellip@milwaukieoregon.gov

District:
District Liaison
Michael Bork
150 Beavercreek Road
Oregon City, OR 97045
Email: Mbork@ncprd.com

8. **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 District without giving effect

to the conflict of law provisions thereof. Any claim between District and City that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Clackamas District 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. City, 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**. District 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. District 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, District shall permit the City'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.** City 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.

K. **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.

L. **Survival.** All provisions in Sections 2, 4 (A-B), 6, and 8 (A), (C), (D), (F), (G-L), and (O) shall survive the termination of this Agreement, together with all other rights and obligations herein which by their context are intended to survive.

M. **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.

N. **Force Majeure.** Neither City nor District shall be held responsible for delay or default caused by events outside of the City or District's reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war. However, City and District 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.

O. **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.

North Clackamas Parks and Recreation District	**City of Milwaukie**
_____	_____
Tootie Smith, Chair, Board of Directors	Ann Ober, City Manager
_____	_____
Date	Date

CITY OF MILWAUKIE

COUNCIL RESOLUTION No. 56-2021

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF MILWAUKIE, OREGON, AUTHORIZING AN INTERGOVERNMENTAL AGREEMENT WITH THE NORTH CLACKAMAS PARKS AND RECREATION DISTRICT (NCPRD) FOR MILWAUKIE BAY PARK PHASE III GRANT ADMINISTRATION, CONSTRUCTION, AND OPERATIONS.

WHEREAS the city wishes to fulfill the community's vision for Milwaukie Bay Park through the construction of a new play area, amphitheater, interactive water feature, picnic space, and plaza; and

WHEREAS the city has worked diligently since the 1990s to plan and construct multiple phases of improvements to the riverfront so that everyone can enjoy the beauty of the Willamette River; and in recognition of its unique position as a regional amenity offering unparalleled river access to the North Clackamas community and serving as a gateway to Clackamas County for visitors entering along highway 99E; and

WHEREAS the city wishes to finalize the grant administration, construction, and operational role commitments for the Milwaukie Bay Park project so that NCPRD can move forward and identify the final resources needed to construct Milwaukie Bay Park.

Now, Therefore, be it Resolved by the City Council of the City of Milwaukie, Oregon, that the city manager is authorized to sign an intergovernmental agreement between the City of Milwaukie and NCPRD for grant administration, construction, and operation of Milwaukie Bay Park Phase III.

Introduced and adopted by the City Council on **November 2, 2021**.

This resolution is effective immediately.

Mark F. Gamba, Mayor

ATTEST:

Scott S. Stauffer, City Recorder

APPROVED AS TO FORM:

Justin D. Gericke, City Attorney

NORTH CLACKAMAS PARKS AND RECREATION DISTRICT
Development Services Building
150 Beavercreek Road, Oregon City, OR 97045

Michael Bork, NCPRD Director

11/24/2021

Board of County Commissioners
Clackamas County
Board of North Clackamas Parks and Recreation District

Members of the Board:

Milwaukie Bay Park Project Design Services –
Contract Amendment #5 with 2.ink Studio Landscape Architecture

Purpose/Outcome	Execution of Amendment #5 to Contract #3105 between NCPRD and 2.ink Studio, P.C. for Design Services for the Milwaukie Bay Park Project
Dollar Amount and Fiscal Impact	The contract fee for amendment #5 is $643,536 for Design Services. The Total Contract Value for this and previously approved work is $809,574. No County General Funds are involved.
Funding Source	System Development Charges (Zone 1) will provide $533,941; NCPRD General Funds will provide $109,595.
Duration	The contract termination date is December 31, 2024, or whenever NCPRD deems the project is complete, whichever is later.
Previous Board Action/Review	• June 28, 2018 Business Meeting: Board approved professional services contract between NCPRD and 2.ink Studio for Milwaukie Bay Park Final Design Services. • 2019-2021 Board approvals: grant submittals, grant agreement, IGA with City of Milwaukie to transfer City funds to NCPRD for project, contract for Owner's Representative Services, and authorization to obtain a Construction Manager/General Contractor. • 2017-2021 Board Updates (5)
Strategic Plan Alignment	**1. *How does this item align with your department's Strategic Business Plan goals?*** • Aligns with the NCPRD Asset Development Strategic result of completing 33% of NCPRD project phases in the annual Capital Improvement Plan • Supports the purpose of the Asset Development program by providing planning and development services to NCPRD residents • Supports the purpose of NCPRD overall by providing access to parks, natural areas, trails, recreation services and facilities ***2. How does this item align with the County's Performance Clackamas goals?***

	• *Honor, Utilize, Promote, and Invest in our Natural Resources* by creating increased tree canopy, increased natural areas, better on-site stormwater utilization, increased floodplain resilience. • *Build a Strong Infrastructure* through improved recreation infrastructure, active transportation corridor and safe access public transportation, and improved stormwater management. • *Build Public Trust through Good Government* by design with inclusive engagement and partnership building to leverage funding. • *Grow a Vibrant Economy* by increasing visitation in the area and attracting more people to the surrounding retail and commercial areas within Clackamas County.
Counsel Review	*1. Date of Counsel review: 11/15/21* *2. Initials of County Counsel performing review: AN*
Procurement Review	1. Was the item processed through Procurement? Yes
Contact Person	Michael Bork, NCPRD Director, x4421 Heather Koch, NCPRD Acting Planning & Development Manager, x4358
Contract No.	#3105

SUMMARY

The attached contract amendment #5 is to support the second phase of design team work for the Milwaukie Bay Park Project. The total fee is not to exceed $643,536. Phases I & II combine for a Total Contract Value of $809,574. Phase II services include: design development, land use submittal, preparation of construction documents, bid support, outreach materials, and construction administration. Construction administration will not commence until NCPRD ensures all requirements are met for construction to move forward. These requirements include: completing all documentation, obtaining approvals and permits, securing all funding, executing an Intergovernmental Agreement with the City of Milwaukie ("City"), and executing a Guaranteed Maximum Price ("GMP") amendment with the construction phase contractor. The contract termination date is December 31, 2024, or whenever NCPRD deems the project is complete, whichever is later. This includes a one-year warranty period. With support from 2.ink Studio, NCPRD plans to conduct design and preconstruction work in FY 21-22 and FY 22-23. Construction start is planned for FY 22-23.

BACKGROUND

NCPRD partnered with the City of Milwaukie in 2018-19 to develop a final design to complete Milwaukie Bay Park as a District-wide recreational waterfront. The design transforms 3.6 acres

of underutilized and predominantly undeveloped land into places to play, rest and gather. Key features include: an amphitheater, nature play area, interactive water feature, plaza with picnic terrace, a permanent alignment for the regional Trolley Trail, pathways, natural areas, public art and restrooms. NCPRD engaged a broad and diverse range of over 1,300 community members in the District during the design phase, advanced a funding strategy to leverage local, regional, state and other funds, and developed a process to build a preconstruction and construction services team in FY20-21.

The park is identified as a high priority need in the 2004 NCPRD Master Plan and 2007 NCPRD Parks and Recreation System Development Charges (SDC) Update Methodology Report and Capital Improvement Plan. The City owns the park and NCPRD plans for, develops and manages the City's parks under a Cooperative IGA. The Cooperative IGA was created as part of the formation of the District in 1990, and last amended in 2020 to reflect the adoption of new bylaws for the District Advisory Committee (DAC).

In 2018, NCPRD selected 2.ink Studio through a competitive RFP process for design services for the Milwaukie Bay Park Project ("Project"). The Board approved the contract on 6/28/18. The contract work supports design services starting with schematic design (Phase 1) and continuing through project completion, including but not limited to preparation of construction documents, permitting services, and construction administration. The initial fee was for a sum not to exceed $166,038 for Phase I. Amendments #1-5 were approved to extend termination date only. To date, the total expended has been $159,081.

As an NCPRD SDC-eligible project, $533,941 in System Development Charges (Zone 1) and $109,595 in NCPRD General Funds will be used for design services. No construction phase funds will be expended until the Project meets requirements to move into construction.

NCPRD's District Advisory Committee continues to review the full project funding. This design contract is part of Total Project Cost of $9,600,000. Currently there is $1,172,715 funding gap, therefore NCPRD staff is reaching out to other partners to identify potential funding sources. The contract work will allow NCPRD to prepare construction documents for the confirmed funding package.

Draft Funding Plan (updated November 2021)

Funding Source	Proposed	Status of Agreements*	Est. Date
City of Milwaukie	250,000	IGA approved; revision pending	Dec 2020 & 2021
Metro-City Local Share	750,000	City engagement and Metro IGA	Apr 2022
NCPRD SDC Zone 1	2,541,875	Construction IGA requested by Board; pending DAC SDC discussions scheduled	Jun 2021, Jun 2022

Metro-NCPRD Local Share	3,000,000	District engagement and Metro IGA pending	Jun 2022
NCPRD Gen Fund	48,475	Annual budget adoption	Jun 2021
State grant (LGGP)	750,000	Grant Agreement approved	Jun 2021
State grant (LWCF)	1,046,935	Grant Agreement pending	Mar 2022
Milwaukie Parks Found.	40,000	Fundraising underway	Spring 2022
Additional Funds	1,172,715	Outreach in process	2022
TOTAL (hard & soft costs)	**9,600,000**	*Final costs must align with budget confirmed*	

PROCUREMENT PROCESS:
This Amendment #5 is in accordance with LCRB C-047-0800(a) for an anticipated amendment. Phase I of the process has been completed and the project is going forward with Phase II which will consist of the Final Design Work and CMGC collaboration.

RECOMMENDATION:
Staff respectfully recommends that the Board, acting as the NCPRD Board of Directors, approve this Amendment #5 to Contract #3105 between NCPRD and 2.ink Studio for Design Services for the Milwaukie Bay Park Project.

ATTACHMENTS:
1. Amendment #5 – To the Contract Documents with 2.ink Studio PC for RFQ 2017-108 Milwaukie Bay Park Final Design

Respectfully submitted,

Michael Bork, Director
North Clackamas Parks and Recreation District

AMENDMENT #5
TO THE CONTRACT DOCUMENTS WITH 2.INK STUDIO PC FOR RFQ 2017-108
MILWAUKIE BAY PARK FINAL DESIGN

Contract #3105

This Amendment #5 is entered into between **2.Ink Studio PC** ("Contractor") and North Clackamas Parks and Recreation District ("District") and shall become part of the Contract documents entered into between both parties on **June 28, 2018** ("Contract").

The Purpose of this Amendment #5 is to make the following changes to the Contract:

1. ARTICLE I, Section 1. **Effective Date and Duration** is hereby amended as follows:
   The Contract termination date is hereby changed from December 31, 2021 to **December 31, 2024 or project completion, whichever is later**.

2. ARTICLE I, Section 2. **Scope of Work** is hereby amended as follows:
   District is requesting Contractor to perform Phase II of the project to include Final Design. The scope of work for Phase II is attached as Exhibit E and hereby incorporated by reference.

3. ARTICLE I, Section 3. **Consideration** is hereby amended as follows:
   In consideration for the additional Work for Phase 2, District is authorizing $643,536.00 to complete the tasks. The budget is included as Exhibit F and the total Contract Compensation shall not exceed $809,574.00.

ORIGINAL CONTRACT	$ 166,038.00
AMENDMENT #1	Time Only
AMENDMENT #2	Time Only
AMENDMENT #3	Time Only
AMENDMENT #4	Time Only
AMENDMENT #5	**$643,536.00**
TOTAL AMENDED CONTRACT	**$ 809,574.00**

Except as expressly amended above, all other terms and conditions of the Contract shall remain in full force and effect. By signature below, the parties agree to this Amendment #5, effective upon the date of the last signature below.

2.Ink Studio, PC

11/10/21
Authorized Signature Date

Jonathan Beaver, Principal
Printed Name

North Clackamas Parks and Recreation District

Chair

Recording Secretary

Date

Approved as to form

11/15/2021
County Counsel Date

Exhibit E

STATEMENT OF WORK

WORKPLAN (PHASE II)

This "Milwaukie Bay Park Final Design Project, Workplan" (the "Workplan") is incorporated into Contract Services between 2.ink Studio and Clackamas County, for the work described herein.

I. Project Understanding

Based on 2.ink Studio's ("Consulting Team") final schematic design for the North Clackamas Parks and Recreation District ("NCPRD") Milwaukie Bay Park, the Consulting Team understands the intent of the Milwaukie Bay Park Project ("Project") as follows. Building upon the completed 2019 schematic design, work for the approximate 3.6-acre scope area will continue to focus on improvements that integrate park amenities and interpretive context, provide for safe, accessible and diverse recreational use, and emphasize the unique character of the park. Work for this contract will focus on a portion of the 6.8-acre site bound by the Willamette River to the west, SE McLoughlin Blvd. to the east, SE Harrison St. to the north and SE Washington St. to the south ("Project Site"), as shown in Figure One (final page of this Exhibit E).

The Consulting Team will provide design development, construction documentation, permitting, GMP set, and construction administration services for the project. In addition, the Consulting Team will provide cost estimating and coordination with a Construction Manager/General Contractor ("CM/GC") administered through NCPRD. The project schedule anticipates work to begin December 2021 with project completion expected end of 2023.

Improvements may include, but are not limited to, community gathering space and pedestrian corridor, children's play area (including traditional and nature play elements), interactive water feature, picnic area(s), grassy open space/amphitheater, native plantings, tree preservation, a restroom/storage building and trellis, stormwater management, elements to deter geese, design to support views, interpretive elements (up to 5), wayfinding signage, site furnishings that enhance a unique park character, and public art. Pedestrian/bike circulation, and pedestrian gateway features and improvements are included as well to integrate surrounding context where existing Trolley Trail and pedestrian access terminates at the site. The Consulting Team's efforts will also include working with NCPRD's selected artist to integrate public art within park improvements.

II. Project Assumptions

The Work Tasks, as set forth in Section III below, have been prepared under the following set of assumptions. These assumptions are based on conversations with NCPRD staff and research accomplished to date by the Consulting Team.

1. The Project Site is defined per Figure One (final page of this Exhibit E), and assumes that current primary vehicular patterns, right-of-ways, adjacent land use and ownership patterns will remain the same for the duration of work. Street work, if any, will be limited to minor modifications at existing curb ramps or curb area striping.

2. The Project Budget for the total hard construction costs (site work plus margins and adjustments) is $7,200,000, excluding artwork. NCPRD acknowledges that the Project Budget and scope may be modified to remain within available funding, but that it is important to work closely with the Consulting Team to continue to meet the requirements of grant agreements for the Project.

3. NCPRD will provide adequate survey information covering the study area to the Consulting Team for the development of a detailed base plan. Survey information will include all property lines, surface improvements, topography, spot elevations on all key elements and grade breaks, site vegetation, underground utilities including invert elevations and all other information necessary to thoroughly document the site and adjacent street entries for construction. The Consulting Team will rely on the accuracy of the survey information when preparing designs and construction documents.

4. The Consulting Team assumes the Project Site does not contain contaminated soils requiring mitigation, nor wetlands.

5. Project assumes no Milwaukie Arts Committee process. The artist will be selected to work with the Consulting Team prior to the start of Construction Documents.

6. To support NCPRD decision-making, the Consulting Team is prepared to organize design documents to accommodate “additional alternate” scope elements to prioritize and align the Project with available funding sources. Prior to initiating design work, NCPRD, Consulting Team and CM/GC will work collaboratively to identify candidate scope elements and dates by when direction is needed consistent with design milestones.

7. NCPRD will pay for all permit applications, fees, and appeals directly.

8. Expenses include up to five full-size printed sets of drawings and specifications for CM/GC use.

9. Drawings and Specifications shall comply with all applicable federal, state, and local laws, statutes, ordinances, and regulations including those applicable to use, occupancy and accessibility. The Consulting Team shall at its own cost promptly correct any Drawings and Specifications that contain errors, conflicts, or omissions that impair construction.

10. NCPRD has designated Shiels Obletz Johnsen to serve as Owner’s Representative. The Owner’s Representative will be NCPRD’s point of contact for communications with the Consulting Team and CM/GC for the duration of the Project.

11. NCPRD will be contracting with a third-party consultant to perform special inspections identified in construction documents prepared by the Consulting Team.

12. NCPRD has provided Consulting Team with a copy of the Clackamas County General Conditions incorporated with the CM/GC contract to be included in Contract Documents and Supplemented as appropriate.

13. Consulting Team does not have authority to provide direction to the CM/GC that impacts either the Guaranteed Maximum Price or CM/GC Contract Term without the prior written approval of NCPRD.

14. NCPRD will be responsible for coordinating communications and approvals with its own NCPRD Board of Directors, as well as external agencies such as the Oregon Department of Transportation and the State Historic Preservation Office. The Consulting Team will be responsible for communications and approvals related to land use and permitting with the City of Milwaukie.

III. Project Schedule

The following is the anticipated project schedule. NCPRD will work with the Consulting Team and CM/GC to determine if construction can start earlier.

- December 2021: Project Kickoff
- February 2022: 50% Design Development Complete
- May 2022: 100% Design Development Complete
- May 2022: Submit Land Use Application
- August 2022: 50% Construction Documents Complete
- November 2022: 95% Construction Documents (GMP & Permit Set) Complete
- January 2023: Start Park Construction
- November 2023: Substantial Completion
- December 2023: Final Completion
- December 2024: One-year Warranty Walk

IV. Work Tasks

Consulting Team agrees to perform the following tasks and activities and provide NCPRD with the deliverables referenced in this Section IV, "Work Tasks."

Task One: Design Development

Upon authorization from the Owner's Representative, the Consulting Team will proceed with design development drawings for the park.

Task One: Goals and Sub-Tasks

- Further develop or refine, based on information gathered in an initial Kick-Off Work Session, the preferred Design Development alternative, proposed products, furnishings, and equipment and continue developing detailed drawings.
- Provide a more refined package of proposed products, equipment, site furnishings, materials, and proposed color chips/samples for all items.
- Provide a detailed cost estimate and outline level technical specifications.

1.01 Design Development Kick-Off Work Session
Participate in half-day Work Session involving NCPRD, CM/GC and key members of Consulting Team to review updated design assumptions, CM/GC Schematic Design cost estimate and project schedule considerations to establish direction for design development work. Summarize design-related comments on the Schematic Design Plan and distribute to NCPRD and CM/GC.

1.02 Update Design Concepts for Restroom/Storage Building
Based on comments from NCPRD and determinations from the further assessment of Redwood tree root zone, confirm desired restroom building size and provide adjustments to the location based on adjacent features. Further develop façade study and relationship to adjacent trellis structure to ensure compatibility with NCPRD maintenance guidelines, aesthetic of park design, and Land Use requirements.

1.03 Conduct Geotechnical Investigation (site specific) & Prepare Final Report
Conduct supplemental geotechnical investigation at the locations of key project elements (e.g. interactive water feature, restroom/picnic overlook, stormwater swale, and event stage) to develop final geotechnical design recommendations and construction guidelines. Geotechnical work will include:

- Excavating up to four test pits with a backhoe to depths up to 10 feet below grade and conducting infiltration testing at a depth of approximately 5 feet below grade at one location.
- Maintaining a log of the soils encountered in the explorations and collecting soil samples for laboratory testing.
- Conducting a program of limited laboratory testing on select samples including moisture content, Atterberg limits, and grain size distribution determination.
- Performing limited engineering analysis to evaluate final foundation, retaining wall, and infiltration design parameters.
- Preparing a letter-report outlining the geotechnical findings and recommendations, including information related subsurface soil and groundwater conditions, earthwork guidelines, infiltration design parameters, retaining wall design, and foundation design parameters.

1.04 Geese Management Analysis & Report
Conduct an analysis of schematic design to determine what elements of design are most effective in deterring and managing geese and what additional standards, changes or additions are recommended to guide design changes, from placement and height of vegetation and structures to

other key components and details. Utilize research provided by NCPRD on local input and regional resources, following up if necessary with sources to clarify any additional standards, changes or additions needed. Summarize needs and changes in report.

1.05 Design Modifications to Plan (Design Development)

The Consulting Team's services shall include but not be limited to a comparison of the CM/GC's estimate of the Cost of the Work based upon the Schematic Design Documents with NCPRD's Project Budget. The Consulting Team's services shall include revisions to the Schematic Design concept for the purpose of aligning the Cost of the Work with NCPRD's Project Budget. Once aligned, the Consulting Team shall request NCPRD's approval to proceed with preparation of Design Development documents.

Provide more detailed drawings, including existing conditions plan (survey), demolition plan including any recommended tree removals and root zone conflicts, grading plan (slope directions and gradients to communicate concepts), preliminary drainage designs, storm water treatment areas, site layout plan (scoring, paving interfaces, primary dimensions only, such as sidewalk widths and overall sizes of features (not detailed layout geometry), materials plan, irrigation zone plan (describe and/or show approach for modifying existing system to accommodate new improvements), planting plan (locations, massing and species alternatives), lighting plan, water feature plans, architectural improvements, and preliminary site details including art concept and plans as developed by NCPRD-contracted artist. Include a more refined package of proposed products, equipment, site furnishings, materials, and proposed colors for all items.

1.06 50% Design Development Package

- Existing Conditions Plan (Survey)
- Civil Stormwater & Utility Plans, Utility Preliminary Details
- Demolition Plan
- Tree Inventory, Mitigation, and Preservation and Removal Plan
- Grading Plan
- Materials Plan
- Preliminary Layout Plan (primary dimensions only)
- Planting Concept Plan and Plant List
- Irrigation Zone Plan
- Preliminary Custom Details
- Water Feature Plans and Details
- Site Structural
- Site Electrical
- Preliminary Restroom/Shade Structure Plans and Details
    - Plumbing
    - Electrical/Low Voltage
    - Structural
    - Fixtures and finishes

1.07 Prepare 50% Design Development Specifications

Prepare outline level specifications to provide basis for cost estimating and coordination between consultants.

1.08 Prepare 50% Design Development Cost Estimate

Construction cost estimates will be prepared to confirm probable costs and to determine that the proposed improvements are within the Project Budget. Seek input from Consulting Team's cost estimating consultant during design process to align design with Project Budget prior to initiating cost estimate. Cost estimate exercises will include coordination and reconciliation with costing by the project CM/GC. Review the construction cost estimates with NCPRD staff to inform NCPRD's decision regarding inclusion of bid alternates.

1.09 Prepare Design Modifications Based on Budget

Compare the Consulting Team's cost estimating consultant estimate and the CM/GC's estimated Cost of the Work based upon the fifty percent (50%) Design Development Documents with the NCPRD's Project Budget. The Consulting Team's services shall include revisions to the fifty percent (50%) Documents for the purpose of aligning the Cost of the Work with the NCPRD's Project Budget. Once aligned, the Consulting Team shall request NCPRD's approval.

1.10 100% Design Development Package

- Existing Conditions Plan (Survey)
- Civil Stormwater & Utility Plans, Utility Preliminary Details
- Demolition Plan
- Tree Inventory, Mitigation, and Preservation and Removal Plan
- Grading Plan
- Materials Plan
- Preliminary Layout Plan (primary dimensions only)
- Planting Concept Plan and Plant List
- Irrigation Zone Plan
- Preliminary Custom Details
- Plans and details to support Artist Work
- Water Feature Plans and Details
- Site Structural
- Site Electrical
- Preliminary Restroom/Shade Structure Plans and Details
    - Plumbing
    - Electrical/Low Voltage
    - Structural
    - Fixtures and finishes

1.11 Prepare 100% Design Development Specifications

Prepare outline level specifications to provide basis for cost estimating and coordination between consultants.

1.12 Land Use Submittal

The Consulting Team shall lead the preparation of application materials and coordination and communication with the jurisdictional authorities regarding all matters associated with the land use approval process.

1.13 Prepare Draft Storm Water Management Report
Prepare draft of soil infiltration testing, reports, forms, calculations and drawings necessary to meet the City of Milwaukie storm water management requirements.

1.14 Administrative/General Coordination/Meeting Minutes
Coordinate communication with Owner's Representative on behalf of Consulting Team to refine project preconstruction schedule, monitor the design team deliverables and schedule, provide written summaries of all meetings attended exclusive of OAC meetings, and monitor Consulting Team invoices and budgets

Task One: Deliverables

- Additional study of restroom building and shade structure to incorporate size as confirmed by NCPRD and determine final location per further investigation of site conditions; review of design and finishes with NCPRD staff to determine suitability for long-term maintenance and Land Use approval.
- Value engineered version of schematic design (if directed by NCPRD)
- Report on Geotechnical Investigation
- Geese Management Report
- Draft Storm Water Report
- 50% and 100% Design Development Packages
- Technical Specifications
- Package of proposed products for unique site amenities including playground equipment, site furnishings, and materials, including web links for each
- Detailed design development cost estimates by cost estimator (at 50% Design Development)
- Prepare SD and DD comments log and track responses
- Comments/corrections to OAC meeting summaries as appropriate
- Written meeting summaries for all meetings attended, except OAC meetings

Task One: Meetings

- One Kick-off Work Session (half day) with NCPRD, CM/GC, and key members of Consulting Team to review updated design assumptions, CM/GC Schematic Design cost estimate, and project schedule considerations to establish direction for design development work. Summarize design-related comments on the Schematic Design Plan and distribute to NCPRD and CM/GC.
- OAC meetings to occur every other week throughout preconstruction
- Internal Design Team meetings – 2.ink and sub-consultants
- Up to two (2) Artist meetings – NCPRD and 2.ink Studio
- Two (2) NCPRD Staff Review meetings
- Meetings as required with jurisdictions having authority over land use approval (anticipate

this to be City of Milwaukie Pre-application Conference and land use hearing at City Planning Commission). Meetings associated with a land use appeal would be considered additional services.
- Up to five (5) meetings with various City of Milwaukie staff and boards (planning, design City Council) and the NCPRD Board (and/or District Advisory Committee)
- One meeting with ODOT to review right of way, permitting and other priorities
- One meeting with architect to discuss design alternatives in detail

Task Two: Construction Documents

Upon authorization by the Owner's Representative, the Consulting Team will proceed with preparation of construction documents.

Task Two: Goals and Sub-Tasks

- Obtain input from NCPRD staff
- Refine project work to provide documentation leading toward a plan set that is consistent with applicable permit requirements and sufficiently detailed to support CM/GC preparation of a Guaranteed Maximum Price.
- Ensure all drawings and specifications contained in Construction Documents are complete and consistent to minimize added cost risk to NCPRD

2.01 Design Modifications Based on Budget

Compare the CM/GC's estimated Cost of the Work based upon the one hundred percent (100%) Design Development Documents with NCPRD's Project Budget. The Consulting Team's services shall include revisions to the one hundred percent (100%) Design Development Documents for the purpose of aligning the Cost of the Work with NCPRD's Project Budget.

Include up to three bid alternates and technical specifications in compliance with NCPRD standards.

Compare the CM/GC's estimated Cost of the Work based upon the fifty percent (50%) Construction Documents with NCPRD's Project Budget. The Consulting Team's services shall include revisions to the fifty percent (50%) Construction Documents for the purpose of aligning the Cost of the Work with NCPRD's Project Budget.

Provide all construction documents necessary to construct the project including construction drawings and technical specifications that are coordinated with Clackamas County General Conditions of the Contract and Division One specifications. NCPRD will provide to the Consulting Team NCPRD's standard requirements and materials. Technical specifications are required in CSI Masterformat. The final version of drawings is required to be produced in a CAD format in .dwg format. The information will be required to be separated into levels (layers) and identified by level (layer) name.

Perform all work necessary to meet the City of Milwaukie Stormwater Management requirements, with assumption that they will be based on new Water Environment Services standards, including soil infiltration testing, reports, forms, calculations, and drawings. Perform all work necessary to meet other codes and requirements and provide a final report of findings.

Seek regular input from CM/GC throughout Construction Documents task to align design with Project Budget, and as directed by NCPRD, adjust the design and/or materials to align the project's cost with the Project Budget, allowing for some alternates to be carried forward through construction documents and CM/GC bidding.

2.02 Prepare 50% Construction Documents (including, but not limited to)

- Existing Conditions Plan (Survey)
- Erosion Control Plan
- Civil Drainage, Storm & Utility Plans, Utility Details
- Demolition Plan
- Tree Mitigation/Tree Preservation and Removal Plan
- Grading Plan
- Materials Plan
- Layout Plan
- Irrigation Plan
- Planting Plan
- Details
- Plans and details to support artist work
- Water Feature Plans and Details
- Site Structural
- Site Electrical
- Restroom/Shade Structure Plans and Details
    - Plumbing
    - Electrical/Low Voltage
    - Structural
    - Fixtures and finishes

2.03 Prepare 50% Construction Document Specifications

Prepare specifications to provide basis for cost estimating, construction standards, and coordination between consultants. Work will include Cover Pages, Contact Pages, Table of Contents, and Technical Specification Sections. Assist NCPRD in coordinating and supplementing General Conditions and Supplemental Reports.

2.04 Prepare Design Modifications Based on Comments

Compare the CM/GC's estimated Cost of the Work based upon the fifty percent (50%) Construction Documents with NCPRD's Project Budget. The Consulting Team's services shall include revisions to the fifty percent (50%) Documents for the purpose of aligning the Cost of the Work with NCPRD's Project Budget.

2.05 Prepare 95% Construction Documents/GMP and Permit Sets (including, but not limited to)

- Existing Conditions Plan (Survey)
- Erosion Control Plan
- Civil Drainage, Storm & Utility Plans, Utility Details
- Demolition Plan
- Tree Mitigation/Tree Preservation and Removal Plan
- Grading Plan
- Materials Plan
- Layout Plan
- Irrigation Plan
- Planting Plan
- Details
- Plans and details to support artist work
- Water Feature Plans and Details
- Site Structural
- Site Electrical
- Restroom/Shade Structure Plans and Details
    - Plumbing
    - Electrical/Low Voltage
    - Structural
    - Fixtures and finishes

2.06 Prepare 95% Construction Documents (Permit Set and GMP Package)

Prepare drawings and specifications to provide basis for pricing, construction standards, and coordination between consultants. Work will include Cover Pages, Contact Pages, Table of Contents, and Technical Specification Sections. Assist NCPRD in coordinating and supplementing General Conditions and Supplemental Reports.

Provide all information including, but not limited to, drawings, specifications, and reports necessary to obtain required site development/building permits.

Prior to permit submittal, if the Owner's Representative determines, at their sole discretion, that the Permit drawings require too many revisions or there are too many outstanding unresolved issues, the issues will be resolved to the satisfaction of the Owner's Representative by the Owner's Representative in coordination with the Consulting Team and the plan reviewers/stakeholders, and the Consulting Team shall make the revisions prior to producing permit sets for submittal.

If the Owner's Representative determines the NCPRD Permit review comments and any unresolved issues are minor enough that the Permit drawings and specifications are sufficient for permit submittal, any remaining NCPRD Permit review comment revisions may be made during the permitting period, prior to producing the 100% CD set.

2.07 Administrative/General Coordination/Meeting Minutes

Coordinate communication with Owner's Representative on behalf of Consulting Team to refine project preconstruction schedule, monitor the design team deliverables and schedule, provide written summaries of all meetings attended exclusive of OAC meetings, and monitor Consulting Team invoices and budgets

Task Two: Deliverables

- Written responses to NCPRD comment log from CD comments
- Stormwater Operations & Maintenance Form, Plan and Specifications, if required for permits
- DEQ 1200c documents, as required
- Certified Arborist Report, if required
- Written summaries of Consulting Team and regulatory agency meetings
- Comments/corrections to OAC meeting summaries as appropriate

50% CD Package

- 50% Construction Documents package
- Technical Specifications
- Revised package of proposed products, equipment, site furnishings, materials, and color chips/samples, including web links for each

95% CD Package (Permit Set and GMP Package)

- Value engineered version of 50% CD cost estimate (if directed by NCPRD)
- 95% Construction Documents package (Permit Set and GMP Package) with up to three bid alternates.
- Technical Specifications
- Revised package of proposed products, equipment, site furnishings, materials, and color chips/samples, including web links for each

Task Two: Meetings

- Up to eleven (11) OAC meetings to occur every other week throughout preconstruction
- Internal Design Team meetings – 2.ink and sub-consultants
- Up to two (2) Artist meetings – NCPRD and 2.ink Studio
- One (1) NCPRD Staff Review meeting
- Up to three (3) meetings with City of Milwaukie, City engineering staff, District Advisory Board (or others in place of these)

Task Three: Bidding

The Consulting Team will assist the CM/GC with any bidding questions.

Task Three: Goals and Sub-Tasks

- Provide additional information to the CM/GC to finalize bid and establish final GMP.

3.01 Issue Addenda

Prepare any addenda based on requested changes during final bidding.

3.02 GMP Set Services/Questions/Substitutions
Prepare all addenda including review of material substitution requests and document clarifications. The Consulting Team will update drawings electronically with all addenda information, and provide the Construction Set of drawings and specifications with all addenda items incorporated.

Assist CM/GC during bidding period providing clarifications, addenda review, substitution requests, pre-bid conference attendance, and answering general questions.

3.03 100% CD (For Construction Set)
Prepare the 100% Construction Set containing all the drawing and specification revisions to date, as well as all permit revisions and bidding revisions. This document will serve as the set used in the field during construction.

3.04 Administrative/General Coordination/Meeting Minutes
Coordinate communication with Owner's Representative on behalf of Consulting Team to refine project preconstruction schedule, monitor the design team deliverables and schedule, provide written summaries of all meetings attended exclusive of OAC meetings, and monitor Consulting Team invoices and budgets

Task Three: Deliverables

- Bid Addenda as needed
- Substitution Requests review and response as needed.
- Construction Set, incorporating all bid addenda revisions, selected alternates and value engineering revisions, and any remaining permit revisions. Includes digital set plus up to five printed sets for use by project team.
- Written meeting summary for all meetings attended, except OAC meetings

Task Three: Meetings

- Up to two (2) OAC meetings
- Up to one (1) Internal Design Team meeting – 2.ink and sub-consultants

Task Four: Permitting
Upon authorization by the Owner's Representative, the Consulting Team will proceed with permit applications based on the permit set prepared in Task 2. The Consulting Team will manage the permit process with the City and coordinate signatures and payments with the Owner's Representative. The Consulting Team will be the applicant and prime point of contact, meaning all communications, check sheets, responses, negotiations, and appeals will flow through them.

Task Four: Goals and Sub-Tasks

- Participate in meetings, and make necessary revisions to obtain permits

4.01 Permit Applications and Forms
The Consulting Team shall take the lead role in preparing application materials and coordinating and communicating with the jurisdictional authorities regarding all matters associated with the permitting and approval process. The Consulting Team will be the applicant and prime point of contact, meaning all communications, check sheets, responses, negotiations, and appeals will flow through them.

4.02 Prepare Final Storm Water Management Report
Prepare final report of soil infiltration testing, reports, forms, calculations and drawings necessary to meet the City of Milwaukie Storm water Management requirements.

4.03 Prepare DEQ 1200c Documents
Prepare DEQ 1200-CN permit application and Standard Erosion Control Template Drawings to City of Milwaukie. Drawings include BMP matrix, notes and details.

4.04 Revisions/Appeal to Permit Set
Provide all additional information, resubmittals, corrections and additions necessary to obtain required site development/building permits, including trips to City of Milwaukie to mark up or attach revisions to the permit review sets as necessary. The Owner's Representative will give direction on revisions.

4.05 Street Improvement Submittal (ODOT)
Provide Street Improvement Documents per ODOT standards for limited work within the right of way, including changes to street utilities, street planting zone trees and shrubs, modifications to existing striping, and modifications to existing curb cuts. Work includes required 30%, 60%, 90% and final submittals. Anticipated signal changes include removal and replacement of a single signal pole at the Monroe Street Plaza.

4.06 Administrative/General Coordination/Meeting Minutes
Coordinate communication with Owner's Representative on behalf of Consulting Team to refine project preconstruction schedule, monitor the design team deliverables and schedule, provide written summaries of all meetings attended exclusive of OAC meetings, and monitor Consulting Team invoices and budgets.

Task Four: Deliverables

- Permit application preparation and submittal
- Revisions to permit sets as necessary to obtain building permit
- Appeal applications as necessary to obtain permits (completed by Owner's Representative)
- Written meeting summary for all meetings attended, except OAC meetings

Task Four: Meetings

- OAC Meetings occurring every other week
- Internal Design Team meeting – 2.ink and sub-consultants

- Meeting to resolve building permit check sheet comments, if necessary

Task Five: Construction Administration Services
Upon authorization by the Owner's Representative, the Consulting Team will proceed with construction administration.

Task Five: Goals and Sub-Tasks

- Provide construction administration services to ensure successful interpretation of the construction documents
- Review operations and maintenance manuals
- Assist NCPRD in close-out procedures
- Attend preconstruction meeting, generally weekly project meetings and site visits during construction, site observation visits as necessary, site observation reports, fabrication plant, nursery and quarry visits as required in the project specifications, additional site visits as necessary for problem solving, samples and mockups
- Communication with the CM/GC through Owner's Representative
- Track all drawing and specification changes throughout the construction process in the electronic files for ease of compiling Record Drawings during Close-Out
- General Conditions: NCPRD and Consulting Team will jointly provide administration of the Contract between NCPRD and the CM/GC as set forth in Clackamas County General Conditions. The Consulting Team shall not advise nor have control over, charge of, or responsibility for the construction means, methods, techniques, sequences or procedures, or for safety precautions and programs in connection with the Work.
- Certificate for Payment: The Consulting Team shall review and certify the amounts due the CM/GC and shall issue certificates in such amounts. The Consulting Team's certification for payment shall constitute a representation to NCPRD, based on the Consulting Team's evaluation of the Work and on the data comprising the CM/GC's Application for Payment, that, to the best of the Consulting Team's knowledge, information and belief, the Work has progressed to the point indicated and that the quality of the Work is in accordance with the Contract Documents.

5.01 Submittals and Shop Drawings Review
Consulting Team shall review Submittal List and Schedule provided by and maintained by the CM/GC to ensure completeness and coordinate review. The Consulting Team shall review and approve or take other appropriate action upon the CM/GC's submittals such as Shop Drawings, Product Data and Samples, but only for the limited purpose of checking for conformance with information given and the design concept expressed in the Contract Documents. Review of such submittals is not for the purpose of determining the accuracy and completeness of other information such as dimensions, quantities, and installation or performance of equipment or systems, which are the CM/GC's responsibility. The Consulting Team's review shall not constitute approval of safety precautions or, unless otherwise specifically stated by the Consulting Team, of any construction means, methods, techniques, sequences or procedures. Incomplete submittals will be rejected.

If the Contract Documents specifically require the CM/GC to provide professional design services or certifications by a design professional related to systems, materials or equipment, the Consulting Team shall specify the appropriate performance and design criteria that such services must satisfy. The Consulting Team shall review Shop Drawings and other submittals related to the Work designed or certified by the design professional retained by the CM/GC that bear such professional's seal and signature when submitted to the Consulting Team. The Consulting Team shall be entitled to rely upon the adequacy, accuracy and completeness of the services, certifications and approvals performed or provided by such design professionals.

5.02 Respond to Requests for Information
The Consulting Team shall review and respond to requests for information about the Contract Documents. The Consulting Team's response to such requests shall be made in writing within any time limits agreed upon, or otherwise with reasonable promptness. If appropriate, the Consulting Team shall prepare and issue supplemental Drawings and Specifications in response to requests for information. Prior to finalizing response, Consulting Team shall review with CM/CG to confirm there is no impact to project schedule or budget.

5.03 Issue Architectural Supplemental Instructions (ASI)
Provide supplemental information to the CM/GC as required to clarify design intent, provide greater detail, or provide information that was otherwise unavailable.

5.04 Substitution Request Review and Response
Provide responses to CM/GC's requests for substitutions during construction.

5.05 Review OAC Meeting Minutes
Review weekly meeting minutes prepared by Owner's Representative and provide corrections as appropriate.

5.06 Evaluation of the Work (Field Reports)
The Consulting Team shall visit the site at intervals appropriate to the stage of construction to become generally familiar with and to keep NCPRD informed about the progress and quality of the portion of the Work completed, (2) to endeavor to guard the NCPRD against defects and deficiencies in the Work, and (3) to determine, in general, if the Work observed is being performed in a manner indicating that the Work, when fully completed, will be in accordance with the Contract Documents. On the basis of the site visits, the Consulting Team shall report to the NCPRD (1) known deviations from the Contract Documents and from the most recent construction schedule submitted by the CM/GC, and (2) defects and deficiencies observed in the Work. The Consulting Team shall provide field reports and documentation for each site visit.

5.07 Project Close Out Document Review
Review Operations and Maintenance Manuals prepared by CM/GC for completeness, providing all comments to NCPRD Project Manager.

5.08 Punch List, Substantial and Final Completion

The Consulting Team's inspection shall be conducted with NCPRD and Owner's Representative to confirm conformance of the Work with the requirements of the Contract Documents and to verify the accuracy and completeness of the list submitted by the CM/GC of Work to be completed or corrected. The Consulting Team will prepare punch list and conduct up to two site visits to ensure items have been closed out.

The Consulting Team shall promptly: conduct inspections to determine the date or dates of Substantial Completion and the date of final completion; issue Certificates of Substantial Completion; receive and review completeness of written warranties, and related documents required by the Contract Documents from the CM/GC and forward to the Owner's Representative, for review and NCPRD records; and recommend issuance of a final Certificate for Payment based upon a final inspection indicating the Work complies with the requirements of the Contract Documents.

5.09 Record Drawings and Specifications (As-Builts)

Review CM/GC provided marked up as-builts and provide comments on their accuracy and completeness. Produce electronic record drawings that include all changes made to the project since the Conformance Set, including owner/design team revisions and the information from CM/GC's as-built mark ups.

5.10 One Year Warranty Visit

Upon request of NCPRD and/or the Owner's Representative, and prior to the expiration of one year from the date of Substantial Completion, the Consulting Team shall, without additional compensation, conduct a meeting with NCPRD and CM/GC to review the facility operations and performance.

Task Five: Deliverables

- Review and certification of Pay Applications
- Review and approval of submittals and shop drawings, including a prompt initial completeness review
- Requests for Information (RFI) responses
- Architect's Supplemental Instructions (ASIs) as necessary
- Substitution Request review and responses
- Substantial Completion punchlist, including items keyed to a key map and photos as appropriate to illustrate deficiencies
- Final Completion punchlist, including items keyed to a key map and photos as appropriate to illustrate deficiencies
- Final Electronic Record Drawings & Specifications (As-Builts)
- Written comments from review of Operations and Maintenance Manuals
- One Year Warranty Visit Report

Task Five: Meetings

- One (1) Pre-Construction Meeting

- Weekly OAC Construction Meetings and Site Observations with NCPRD, Owner's Representative, CM/GC and Consulting Team members as appropriate. Site Observations will occur after or before each weekly meeting and include observation reports as necessary to document progress, deficiencies, and on-site discussions. Meeting notes provided by Owner's Representative.
- Four (4) Nursery/Fabricator/Quarry Visits
- Two (2) Substantial Completion walk-through and punch list
- Two (2) Final Completion walk-through
- One (1) One Year Warranty Visit

Task Six: Supplemental Outreach Materials
Upon authorization by the Owner's Representative, the Consulting Team will proceed with providing supplemental outreach materials on an hourly/not-to-exceed basis. The purpose of these materials is to support continued public outreach for the project centered around specific project areas as appropriate, such as the water feature, playground, or other site features.

Task Six: Goals and Sub-Tasks

- Provide colored and annotated plan graphics.
- Provide updates to 3D modelling and rendered views.
- Provide updates to previous renderings, plans, or diagrams.
- Provide narratives or precedent imagery of any design elements.

Task Seven: Early Earthwork Package
Upon authorization by the Owner's Representative, the Consulting Team will proceed with preparation of an early earthwork package at around the time of the 50% Construction Document Set to procure a grading permit to allow site grading operations to begin prior wet weather conditions on the site.

Task Seven: Goals and Sub-Tasks

- Obtain input from NCPRD staff
- Refine project work to provide documentation leading toward a plan set that is permittable and suitable for setting Guaranteed Maximum Price and proceeding with construction with CM/GC.

7.01 Prepare 100% Construction Documents for Rough Earthwork
Set will include, but not limited to:
- Existing Conditions Plan (Survey)
- Erosion Control Plan
- Civil Drainage, Storm & Utility Plans, Utility Details (confirm)
- Demolition Plan
- Tree Mitigation/Tree Preservation and Removal Plan
- Grading Plan
- General Site Plan (for reference only)

7.02 Revisions/Appeal to Permit Set
Provide all additional information, resubmittals, corrections and additions necessary to obtain required grading permits, including trips to City of Milwaukie to mark up or attach revisions to the permit review sets as necessary.

7.03 Administrative/General Coordination
Including communication within Consulting Team and with Owner's Representative, refining project schedule, monitoring the design team deliverables and schedule, invoices and budgets, and facilitating communication between NCPRD and Consulting Team.

Task Seven: Deliverables

- Permit Documents package
- Revisions to Permit Documents as required by City.

Task Seven: Meetings

- Up to one (1) meeting with City of Milwaukie or City engineering staff

Task Eight: Interpretive Elements

Upon authorization by the Owner's Representative, the Consulting Team will proceed with preparation of interpretive elements for the project.

Task Eight: Goals and Sub-Tasks

- Conduct Historical Research for use in interpretive elements and/or public art.
- Develop graphic interpretive elements (up to 5)

8.01 Historical Research and Interpretive Concepts
Conduct further research into the City of Milwaukie's downtown, park, and area history. With guidance from NCPRD and Consulting Team, expand on the Historical Overview and Historical Themes prepared in Schematic Design Phase. Prepare a final report to discuss with project team. Write narratives for up to five (5) topic areas that may be developed into specific interpretive features integrated into the park's infrastructure. Research will include text, images, and timelines. Interpretive elements may be text and/or image based and will be integrated into park elements designed by the Consulting Team, stand-alone interpretive plaques, or artwork to be developed for installation at the park. Integrate information into appropriate previous Tasks as needed: Design Development Documents in conjunction with Task 1; Construction Documents in conjunction with Task 2; Bidding tasks in conjunction with Task 3; and Construction Administration in conjunction with Task 5.

Task Eight: Deliverables

- Historical Research Final Report and Interpretive Narratives
- Written text for five (5) themes
- 50% and 100% Design Development Documents

- 50% and 100% Construction Documents

Task Eight: Meetings

- Meetings in coordination with OAC meetings or others as integrated with Tasks 1-5.

Figure One - Project Site

EXHIBIT F

MILWAUKIE BAY PARK **Proposed Cost of Design** **11/9/2021** **Task / Phase**	**2.ink Studio**			**Zucker Engineering**	**ESA**		**Material Architecture**		**Nemariam Engineers**			**Grummel Engineering**		**R&W Engineering**				**Hart Crowser**					**STO Design Group, Inc.**			**Consulting Historian**	**Rider Levett Bucknall**		**Ambrosini Design**	**Pacific Resources**	**Estimate / by Task**
	JB	CO	TECH	ASZ	JV	LJ/TR	TF	staff	Sr. Mngr.	Proj Mngr	QC Eng.	RJG	JW	SrEngr II	SrEngr I	SrTech II	CAD	Principal	Project	Sr. Staff	Drafter	PA	DS	MK	PF	consultant	SR CM	CM	STAFF	STAFF	
	$139	$113	$82	$140	$160	$120	$175	$100	$201	$146	$178	$200	$180	$160	$130	$125	$75	$265	$160	$140	$125	$100	$250	$210	$160	$100	$210	$200	$125	$190	
Task One: Design Development/Land Use Submittal																															
OAC Meetings (10)	14	16		8											3	3								2						3	49
Design Team Coordination Meetings (8)	12	12		16	4		2	2	2			2	8		3	3															66
Artist Meetings (2)	2	2																													4
NCPRD Staff Review (2)	4	4		3																											11
Misc. Advisory Meetings (5)	10	10																													20
Pre-application for Land Use and Land Use Hearing at Planning Commission (2)	4	4		6	4																										18
Early Assistance City Engineering (1)	2	2		3																											7
ODOT Meeting (1)	2	2		2																											6
Architect Meeting	2	2					2	2																							8
1.01 Kickoff Meeting	4	4		2	2		2	2				1			3									1							21
1.02 Update Design Concepts for Restroom/Storage Bldg	2	8	2				8	32				1	2		2	2															59
1.03 Conduct Geotechnical Investigation & Prepare Final Report																		4		20	4	3									31
1.04 Geese Management Analysis & Report	2	8	8	4																											22
1.05 Design Modifications to Plan	16	20	32							4			2		3	4	4														85
1.06 Prepare 50% Design Development Drawings	4	60	140	24			8	32				1	12		4	4	4						2	6	16						317
1.07 Prepare 50% Design Development Specifications	16	2		6			5	8					4		2	2								2							47
1.08 Prepare 50% Design Development Cost Estimate	2	2		4											4	4								1		22	25				64
1.09 Design Modifications Based on Budget	4	12	20	6			5	22							4	4	4														81
1.10 Prepare 100% Design Development Drawings	4	60	140	30			8	24					6		2	2	4						2	8	21.5						311.5
1.11 Prepare 100% Design Development Specifications	16	2		6									2		2	2							1	3							34
1.12 Prepare Land Use Submittal and Narrative	2	2		14	78	48																									144
1.13 Prepare Draft Storm Water Report				20																											20
1.14 Administrative/General Coordination/Meeting Minutes	16	22							1																						39
Task One - Subtotal Staff Hours	140	256	342	154	88	48	40	124	3	4	0	5	36	0	32	30	16	4	0	20	4	3	5	23	37.5	0	22	25	0	3	1464.5
Task One - Subtotal Staff Labor Cost	$19,460	$28,928	$28,044	$21,560	$14,080	$5,760	$7,000	$12,400	$603	$584	$0	$1,000	$6,480	$0	$4,160	$3,750	$1,200	$1,060	$0	$2,800	$500	$300	$1,250	$4,830	$6,000	$0	$4,620	$5,000	$0	$570	
TASK ONE - TOTAL LABOR FEE	**$76,432**			**$21,560**	**$19,840**		**$19,400**		**$1,187**			**$7,480**		**$9,110**				**$4,660**					**$12,080**			**$0**	**$9,620**		**$0**	**$570**	**$181,939**
Task Two: Construction Documents/ GMP Set																															
Key Meetings: OAC Meetings (11)	22	22		4																											48
Key Meetings: Design Team Coordination Meetings (8)	12	12		10			2	2	2						3	3		4						8						3	61
Key Meetings: Artist Meetings (2)	2	2																													4
Key Meetings: CM/GC Meetings (6)	9	9		4											3	3															28
Key Meetings: NCPRD Staff Review (1)	2	2		2																											6
Key Meetings: Misc. Advisory Meetings (2)	4	4																													8
Key Meetings: City Engineering Meeting (1)	2	2		3																											7
2.01 Design Modifications Based on Budget (if required)	8	20	40				4	12							8	8	4														104
2.02 Prepare 50% Construction Document Drawings	40	80	240	30			4	32				1	6		20	16	8						2.5	14	24.25						517.75
2.03 Prepare 50% Construction Document Specifications	16	2		6									1		4	4							1	2							36
2.04 Design Modifications Based on Comments (if required)	4	12	20	10											4	4	4														58
2.05 Prepare 95% Construction Document Drawings (GMP/Permit Set)	41	98	274	70			12	48				1	14	2	16	16	12	1	4				2	11	26						648
2.06 Prepare 95% Construction Document Specifications (GMP/Permit Set)	16	2		8			4	8					1		2	2		1	4			1	1	2							52
2.07 Administrative/General Coordination/Meeting Minutes	16	19							2																						37
Task 2 - Subtotal Staff Hours	194	286	574	147	0	0	26	102	4	0	0	2	22	2	60	56	28	6	8	0	0	1	6.5	37	50.25	0	0	0	0	3	1614.75
Task 2 - Subtotal Staff Labor Cost	$26,966	$32,318	$47,068	$20,580	$0	$0	$4,550	$10,200	$804	$0	$0	$400	$3,960	$320	$7,800	$7,000	$2,100	$1,590	$1,280	$0	$0	$100	$1,625	$7,770	$8,040	$0	$0	$0	$0	$570	
TASK TWO - TOTAL LABOR FEE	**$106,352**			**$20,580**	**$0**		**$14,750**		**$804**			**$4,360**		**$17,220**				**$2,970**					**$17,435**			**$0**	**$0**		**$0**	**$570**	**$185,041**
Task Three: Bidding																															
Key Mtngs: OAC Meetings (2)	4	4		3											3	3															17
Key Mtngs: Design Team Coordination Meetings (1)	1.5	1.5		2			2	2							2	2								1							14
3.01 Issue Addenda	1	12	12	4											4	4	2														39
3.02 GMP Set Services/Questions/Substitutions	1	16		4			2	4							4	4								2	4						41
3.03 Issue For Construction Set	1	8	20	12				4					2	2	4	4	2						1	1	2						63
3.04 Administrative/General Coordination/Meeting Minutes	4	14																													18
Task 3 - Subtotal Staff Hours	12.5	55.5	32	25	0	0	4	10	0	0	0	0	2	2	17	17	4	0	0	0	0	0	1	4	6	0	0	0	0	0	192
Task 3 - Subtotal Staff Labor Cost	$1,738	$6,272	$2,624	$3,500	$0	$0	$700	$1,000	$0	$0	$0	$0	$360	$320	$2,210	$2,125	$300	$0	$0	$0	$0	$0	$250	$840	$960	$0	$0	$0	$0	$0	
TASK THREE - TOTAL LABOR FEE	**$10,633**			**$3,500**	**$0**		**$1,700**		**$0**			**$360**		**$4,955**				**$0**					**$2,050**			**$0**	**$0**		**$0**	**$0**	**$23,198**

Task Four: Permitting																															
Key Mtngs	OAC Meetings (3)	6	6																												12
	Design Team Coordination Meetings (1)	1.5	1.5		3			2	2							2	2						1								15
	City Staff Meetings (1)	2	2		3																										7
4.01	Assist City PM with Permit Applications and Forms	4	8		4																									8	24
4.02	Final Storm Water Management Report	0.5	1		16																										17.5
4.03	Prepare DEQ 1200c Documents		1		6																										7
4.04	Revisions/Appeal to Permit Set	2	12	20	24			4	12					4	2	4	4	4													92
4.05	Street Improvement Submittal (ODOT)	2	20	20	20					2	32	8				2	2														108
4.06	Administrative/General Coordination/Meeting Minutes	2	13																												15
Task 4 - Subtotal Staff Hours		20	64.5	40	76	0	0	6	14	2	32	8	0	4	2	8	8	4	0	0	0	0	0	0	1	0	0	0	0	8	297.5
Task 4 - Subtotal Staff Labor Cost		$2,780	$7,289	$3,280	$10,640	$0	$0	$1,050	$1,400	$402	$4,672	$1,424	$0	$720	$320	$1,040	$1,000	$300	$0	$0	$0	$0	$0	$0	$210	$0	$0	$0	$0	$1,520	
TASK FOUR - TOTAL LABOR FEE		**$13,349**			**$10,640**	**$0**		**$2,450**		**$6,498**			**$720**		**$2,660**				**$0**					**$210**			**$0**			**$1,520**	**$38,047**
Task Five: Construction Administration																															
Key Mtgs	Pre-Construction Meeting (1)	2	2		3											2	2													1	12
	Weekly Construction Meetings (40)	20	160		20									8		6	6							8						16	
	Nursery/Fabricator/Quarry Visits as Required (4)	16	16																												32
	Substantial Completion (2)		12		4			2	2							2	2							8							
	Final Walk-Through (2)		12		4			2	2					2		2	2														26
5.01	Submittals and Shop Drawings Review	2	60		2									6		8	8							4	2						92
5.02	Respond to Requests for Information	2	40		4			4	8					3		4	4		2	6			1	2							80
5.03	Issue Architectural Supplemental Instructions (ASI)	2	40		4			4	8					2										1	1						62
5.04	Substitution Request Review and Response	2	8		4			2	4					2		4	4							2							32
5.05	Review OAC Meeting Minutes		20																												20
5.06	Evaluation of the Work (Field Reports)		80						8																						88
5.07	Project Close Out Document Review	2	8		2			1								2	2							2							19
5.08	Punch List, Substantial and Final Completion		4		3			3	4							4	4							4							26
5.09	Record Drawings and Specifications (As Builts)	3	12		10			1	8						1	5	4	2						3	2						51
5.10	One Year Warranty Visit and Report	1	8																												9
Task 5 - Subtotal Staff Hours		52	482	0	60	0	0	19	44	0	0	0	0	23	1	39	38	2	2	6	0	0	1	0	34	5	0	0	0	0	17	825
Task 5 - Subtotal Staff Labor Cost		$7,228	$54,466	$0	$8,400	$0	$0	$3,325	$4,400	$0	$0	$0	$0	$4,140	$160	$5,070	$4,750	$150	$530	$960	$0	$0	$100	$0	$7,140	$800	$0	$0	$0	$0	$3,230	
TASK FIVE - TOTAL LABOR FEE		**$61,694**			**$8,400**	**$0**		**$7,725**		**$0**			**$4,140**		**$10,130**				**$1,590**					**$7,940**			**$0**			**$3,230**	**$104,849**
Task Six: Supplemental Outreach Materials																															
6.01	Supplemental Outreach Materials	16	40	40																											96
Task 6 - Subtotal Staff Hours		16	40	40	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	96
Task 6 - Subtotal Staff Labor Cost		$2,224	$4,520	$3,280	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
TASK SIX - TOTAL LABOR FEE		**$10,024**			**$0**	**$0**		**$0**		**$0**			**$0**		**$0**				**$0**					**$0**			**$0**			**$0**	**$10,024**
Task Seven: Early Earthwork Package																															
Mtg	City Staff Meeting (1)		2		3																										5
7.01	Prepare Earthwork Construction Document Package	2	16	24	12																										54
7.02	Revisions/Appeal to Permit Set		8		4																										12
7.03	Administrative/General Coordination	1	4		4																										9
Task 7 - Subtotal Staff Hours		3	30	24	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	80
Task 7 - Subtotal Staff Labor Cost		$417	$3,390	$1,968	$3,220	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
TASK SEVEN - TOTAL LABOR FEE		**$5,775**			**$3,220**	**$0**		**$0**		**$0**			**$0**		**$0**				**$0**					**$0**			**$0**			**$0**	**$8,995**
Task Eight: Interpretive Elements																															
Mtg	OAC Meetings/Other Meetings																									6			18		24
8.01	Historical Research and Interpretive Concepts	16	8	16																						185			148		373
Task 8 - Subtotal Staff Hours		16	8	16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	191	0	0	166	0	397
Task 8 - Subtotal Staff Labor Cost		$2,224	$904	$1,312	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$19,100	$0	$0	$20,750	$0	
TASK EIGHT - TOTAL LABOR FEE		**$4,440**			**$0**	**$0**		**$0**		**$0**			**$0**		**$0**				**$0**					**$0**			**$19,100**			**$20,750**	**$0**	**$44,290**
Total Staff Hours		454	1222	1068	485	88	48	95	294	9	36	8	7	87	7	156	149	54	12	14	20	4	5	13	99	99	191	22	25	166	31	
Total Staff Labor Cost		$63,037	$138,086	$87,576	$67,900	$14,080	$5,760	$16,625	$29,400	$1,809	$5,256	$1,424	$1,400	$15,660	$1,120	$20,280	$18,625	$4,050	$3,180	$2,240	$2,800	$500	$500	$3,125	$20,790	$15,800	$19,100	$4,620	$5,000	$20,750	$5,890	
TOTAL PROJECT LABOR FEE		**$288,699**			**$67,900**	**$19,840**		**$46,025**		**$8,489**			**$17,060**		**$44,075**				**$9,220**					**$39,715**			**$19,100**			**$20,750**	**$5,890**	**$596,383**
ESTIMATED EXPENSES		**$5,000**			**$750**	**$200**		**$500**		**$500**			**$500**		**$1,000**				**$2,200**					**$3,000**			**$500**			**$500**	**$200**	**$15,350**
10% MANAGEMENT MARKUP																															**$31,803**
GRAND TOTAL																															**$643,536**

CLACKAMAS
WATER ENVIRONMENT SERVICES

GREGORY L. GEIST | DIRECTOR
Water Quality Protection
Surface Water Management
Wastewater Collection & Treatment

November 24, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of the Intergovernmental Agreement between
Water Environment Services and City of Estacada for Hauling and Storage Services
No County General Funds are involved.

Purpose/Outcomes	Approval of the Intergovernmental Agreement between Water Environment Services and City of Estacada for Hauling and Storage Services. No County General Funds are involved.
Dollar Amount and Fiscal Impact	N/A
Funding Source	No general fund dollars.
Duration	The Agreement ends November 30, 2024, with options for extensions.
Previous Board Action/Review	This item was presented for a temporary emergency agreement in February, 2021.
Strategic Plan Alignment	1. This project supports the WES Strategic Plan to beneficially reuse biosolids produced at the Water Resource Recovery Facilities and to support regional disposal options and provide wastewater treatment services to members of the community. 2. This service supports the County Strategic Priority to ensure safe, healthy, and secure communities.
Counsel Review	Date of Counsel review: 10/21/2021 Name of County Counsel performing review: Amanda Keller
Procurement Review	Was the item processed through Procurement? Yes ☐ No ☒ If no, provide a brief explanation: Item is an Intergovernmental Agreement with the City of Estacada.
Contact Person	Terrance Romaine, 503-557-2821, tromaine@clackamas.us
Contract No.	N/A

BACKGROUND:
Due to capacity issues and limited land application in winter months, the City of Estacada desires immediate assistance with hauling and storage of approximately 70,000 gallons of Class B biosolids ("City Biosolids") generated at the City's treatment facility. The District is willing to accept at the Kellogg Creek Water Resource Recovery Facility ("Kellogg WRRF") or Tri- City Water Resource Recovery Facility ("Tri-City WRRF") on an as needed basis during the duration of this agreement.

RECOMMENDATION:
WES staff recommends the Board, acting as the governing body of Water Environment Services, approve the Intergovernmental Agreement between Water Environmental Services and the City of Estacada for Hauling and Storage Services.

Respectfully submitted,

Greg Geist
Director, Water Environment Services

Attachment: Intergovernmental Agreement between Water Environmental Services and the City of Estacada

CLACKAMAS
WATER
ENVIRONMENT
SERVICES

RECORDING MEMO

☑ New Agreement/Contract

☐ Amendment/Change/Extension

☐ Other: _____

Originating County Department: Water Environment Services

Purchasing for: _____

Other party to contract/agreement: City of Estacada

Title from Business Meeting Agenda: Approval of the Intergovernmental Agreement between Water Environment Services and City of Estacada for Hauling and Storage Services.

After recording please return to:

Water Environment Services
c/o Lauren Haney, Administrative Services
150 Beavercreek Road, Suite 430
Oregon City, OR 97045

Clerk to the Board please complete below this line after Board approval

Board Agenda Date: _____

Agenda Item Number: _____

INTERGOVERNMENTAL AGREEMENT
BETWEEN WATER ENVIRONMENT SERVICES
AND THE CITY OF ESTACADA
FOR HAULING AND STORAGE SERVICES

THIS AGREEMENT (this "Agreement") is entered into and between Water Environment Services ("District"), an intergovernmental entity formed pursuant to ORS Chapter 190, and the City of Estacada ("City"), an Oregon municipal corporation, collectively referred to as the "Parties" and each a "Party."

RECITALS

Oregon Revised Statutes Chapter 190.010 confers authority upon local governments to enter into agreements for the performance of any and all functions and activities that a party to the agreement, its officers or agencies have authority to perform.

Due to capacity issues and limited land application in winter months, the City desires immediate assistance with hauling and storage of approximately 70,000 gallons of Class B biosolids ("City Biosolids") generated at the City's treatment facility. The District is willing to accept at the Kellogg Creek Water Resource Recovery Facility ("Kellogg WRRF") or Tri- City Water Resource Recovery Facility ("Tri-City WRRF") pursuant to the terms of this Agreement (collectively, the "District Facilities").

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 November 31, 2024.
2. **Scope of Services.** The District and the City agree to the obligations and conditions identified in the Scope of Services, attached hereto as Exhibit A and incorporated herein ("Services").
3. **Consideration.** The City agrees to pay the District the price of $0.10 per gallon of City Biosolids delivered to District Facilities. This fee may be adjusted from time to time by the Parties, without need for further amendment of this Agreement. All fee adjustments shall be based on changes to the District's rates and charges.
4. **Payment.** The District will submit monthly invoices to the City for Services rendered in accordance with the terms of this Agreement. The City agrees to pay invoices within thirty (30) days of receipt.
5. **Representations and Warranties.**
   A. *City Representations and Warranties*:
      i. City represents and warrants to District that City has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of City enforceable in accordance with its terms.

ii. City represents and warrants that all City Biosolids delivered to District Facilities will be Class B biosolids as defined in Oregon Administrative Rules Chapter 340, Division 50 and 40 CFR Part 503.

B. *District Representations and Warranties*:

i. District represents and warrants to City 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.

ii. The District warrants that any services it furnishes under this Agreement will be in compliance with OAR Chapter 340, Division 50 and 40 CFR part 503 and other applicable federal, state and local laws.

C. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

6. **Suspension; Termination.**

A. Suspension. The District may immediately suspend and refuse to furnish Services under this Agreement if the City Biosolids fail to meet the Class B standard defined in Section 5 above or are otherwise determined by the District, in its sole discretion, not to be suitable for discharge to District Facilities. The District will provide prompt notice to the City of any suspension in Services.

B. Termination.

i. Either the District or the City may terminate this Agreement at any time upon thirty (30) days written notice to the other party.

ii. Either the District or the City 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.

iii. The District or the City shall not be deemed to have waived any breach of this Agreement by the other Party except by an express waiver in writing. An express written waiver as to one breach shall not be deemed a waiver of any other breach not expressly identified, even though the other breach is of the same nature as that waived.

iv. The District may terminate this Agreement in the event the District fails to receive expenditure authority sufficient to allow the District, in the exercise of its reasonable administrative discretion, to continue to perform under this Agreement, or if federal or state laws, regulations or guidelines are modified or

interpreted in such a way that either the Project under this Agreement is prohibited or the District is prohibited from paying for such work from the planned funding source.

v. 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 District agrees to indemnify, save harmless and defend the City, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the District or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the District has a right to control.

Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the City agrees to indemnify, save harmless and defend the District, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the City or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the City has a right to control.

8. **Insurance.** The City agrees to furnish the District with evidence of commercial general liability insurance with a combined single limit of not less than $1,000,000 for each claim, incident, or occurrence, with an aggregate limit of $2,000,000 for bodily injury and property damage for the protection of Clackamas District, and their officers, elected officials, agents, and employees against liability for damages because of personal injury, bodily injury, death or damage to property, including loss of use thereof, in any way related to this Agreement. If self-insured, City shall provide documentation to the District of City's self-insured status by completing the Self-Insurance Certification form provided by the District.

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. Terrance Romaine or their designee will act as liaison for the District.

Contact Information:

Water Environment Services
15941 S. Agnes Ave.
Oregon City, OR 97045
Phone: 503-557-2821
Email: tromaine@clackamas.us

Chris Lewis or their designee will act as liaison for the City.

Contact Information:

City of Estacada, Plant Operations Manager
800 NW Evergreen Way
Estacada, OR 97023
Phone: 503.630.8270 x219
Email: lewis@cityofestacada.org

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 the District and Clackamas County, without giving effect to the conflict of law provisions thereof. Any claim between District and City that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Clackamas County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the 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. The City, 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**. City 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. City shall maintain all financial records in accordance with generally accepted accounting principles. All other Records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, City shall permit the District's authorized representatives' access to the Records at reasonable times and places for purposes of examining and copying.

E. **Work Product.** Reserved.

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.** City 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**. City shall not enter into any subcontracts for any of the work required by this Agreement, or assign or transfer any of its interest in this Agreement by operation of law or otherwise, without obtaining prior written approval from the District, which shall be granted or denied in the District's sole discretion. District's consent to any subcontract shall not relieve City 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**. The Parties agree 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 City nor District shall be held responsible for delay or default caused by events outside of the City or District's reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war. However, City 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**. Reserved.

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.

[*Signature Page Follows*]

IN WITNESS HEREOF, the Parties have executed this Agreement by the date set forth opposite their names below.

Water Environment Services

_____
Chair

_____
Date

City of Estacada

_____
Authorized Signatory

Plant operations manager
Title

1-17-2021
Date

EXHIBIT A – SCOPE OF SERVICES

City of Estacada and Water Environment Services IGA

A. CITY OBLIGATIONS AND DISPOSAL CONDITIONS

1. Class B Biosolids. At or prior to delivery, the City will provide District with characteristics data that demonstrates that the City Biosolids meet the requirements of Class B Biosolids defined in Oregon Administrative Rules Chapter 340, Division 50 and 40 CFR Part 503 ("Class B Requirements"). If the City Biosolids do not meet the Class B Requirements, then the District may refuse acceptance of the City Biosolids.

2. Measurement of Discharge Volume. The City will determine the volume of Biosolids discharged by using one of two methods:

a) Subtracting the empty truck weight from the full weight and converting the weight of the material discharged to gallons. Truck weights can be determined by use of scales at available at Tri-City WRRF.

b) If the actual capacity of the truck tank is known, using the known volume and assuming the a full tank was discharged

3. Interference. If District determines, in its sole discretion, that the City Biosolids are: a) causing, or could cause interference with District facility operations, including, but not limited to, any interference or pass-through that might cause District Facility to exceed any condition of its NPDES permit; b) contains contamination that could make District's biosolids or recycled water unsuitable for their intended uses; or c) otherwise not suitable for discharge to District facilities, District may suspend Services in accordance with Section 6(A) of the Agreement.

4. Spills/Cleanup. The City must prevent spills or tracking of City Biosolids at District Facilities. The City shall be responsible for the clean up and removal from District's premises of all spills, contaminated matter, and contaminated clean up material, in addition to all costs of any nature (including fines, etc.) related to spills or tracking.

5. District Hours and Location of Operation. The City may unload the City Biosolids at times approved by District at the Kellogg Creek Water Resource Recovery Facility located at 11525 SE McLoughlin Blvd Milwaukie, OR 97222, or at the Tri-City Water Resource Recovery Facility at 15941 S. Agnes Ave. Oregon City, OR 97045.

6. Hauling Tickets. The City shall be responsible for providing a hauling ticket for each load of City Biosolids that are hauled to District facilities in order to document the number of gallons discharged.

7. Sampling Procedure. The City shall collect a representative sample of the City Biosolids and deliver it to District on the discharge date.

8. Off-loading Biosolids. The City shall off-load at the disposal point designated by District. The City shall notify District personnel prior to discharge, in order to allow District staff to monitor the discharge. Contact information for District personnel will provided by District.

9. Compliance with Terms. The City shall ensure that all City employees and representatives have read, understood and agreed to the terms and conditions contained herein regarding hauling, delivery, off-loading and cleanup.

10. Obligation of Disposal. This Agreement does not obligate City to dispose of City Biosolids at any District Facility.

B. DISTRICT OBLIGATIONS AND DISPOSAL CONDITIONS

1. Acceptance/Amount. The District, in its sole discretion, will determine the amount, if any, and rate of City Biosolids it will accept and beneficially use.