Commissioners encourage public to attend public meeting digitally.

CLACKAMAS COUNTY

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

AGENDA

Thursday, April 16, 2020 - 10:00 AM
BOARD OF COUNTY COMMISSIONERS

Beginning Board Order No. 2020-28

CALL TO ORDER
- Roll Call
- Pledge of Allegiance

***COVID-19 Update

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

1. Proclaiming April 12-18, 2020 as National Public Safety Telecommunicator Week and Recognizing 9-1-1 Telecommunicators as Emergency Responders in Clackamas County (Cheryl Bledsoe, Central Communications (911))

II. HOUSING AUTHORITY PUBLIC HEARING

1. Public Hearing on the Proposed 2020-2021 Housing Authority of Clackamas County Annual Plan (Jill Smith, Housing Authority of Clackamas County)

III. HOUSING AUTHORITY CONSENT AGENDA

1. Approval of the Hillside Manor Guaranteed Maximum Price Amendment to the CMGC Contract with Walsh Construction – *HACC*
2. Approval of Resolution No 1944 Authorizing the Execution, Acknowledgement and Delivery of Closing Documents for the Hillside Manor Rehabilitation Project

IV. PUBLIC HEARING *(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.)*

1. Resolution to Amend the Transportation System Development Charges Methodology Report, Modifying the TSDC Rate Schedule to Establish New Rates for Single Family Residential Homes and Accessory Dwelling Units
(Diedre Landon, Department of Transportation & Development)

V. 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. Finance Department

1. Board Order No. _____ Authorizing Financings for New Projects and Refinancing

B. Elected Officials

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

C. Department of Human Resources

1. Approval of the 2020 Agreements with Providence Health Plan for Administrative Services for Clackamas County's Self-Funded Medical Benefits

D. Business & Community Services

1. Approval of a Lease Agreement between Clackamas County and River City Boat Sales, LLC to Lease, Manage and Operate the Boones Ferry Marina Facility – *County Parks*

2. Approval of a Contract with Janz Enterprises, Inc. for the Carver Boat Launch Parking Lot Curb Replacement and Asphalt Overlay - *Procurement*

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

VII. COUNTY ADMINISTRATOR UPDATE

VIII. 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

Cheryl Bledsoe, Director
Department of Communications

Communications and Emergency Operations Center
2200 Kaen Road, Oregon City, OR 97045

April 16, 2020

Board of County Commissioners
Clackamas County

Members of the Board:

Proclamation to Recognize 9-1-1 Telecommunicators as Emergency Responders and Recognize National Public Safety Telecommunicator Week as April 12-18, 2020

Purpose/Outcomes	Recognize the important work that 9-1-1 call-takers, dispatchers, technicians, trainers, supervisors and administrators do to provide 9-1-1 services to the residents of Clackamas County.
Fiscal Impact	No fiscal impact
Contact Person	Cheryl Bledsoe (503) 723-4875

BACKGROUND:
Across the nation in times of intense personal crisis and community-wide disasters, the first access point for those seeking all types of emergency services is 9-1-1. The local and county emergency communications centers that receive these calls have emerged as the first and single point of contact for persons seeking immediate relief during an emergency.

Clackamas 911 Communications, known as C-COM, is celebrating the second full week of April (April 12-18, 2020) as National Public Safety Telecommunicators Week. This week, sponsored by the Association of Public-Safety Communications Officials (APCO) International and celebrated annually since 1981, honors the thousands of men and women who respond to emergency calls, dispatch public safety responders, and render life-saving assistance to the residents of Clackamas County.

This past year, C-COM answered just over 269,000 9-1-1 calls and non-emergency calls for residents in our jurisdiction. In addition, we answered 304 reported incidents over our “text-to-911” service which involved 2,476 total text-based messages. Beyond the call statistics, C-COM provided dispatch support for nearly 207,995 law enforcement incidents, 7,745 fire events and 29,544 Emergency Medical Service (EMS) events in which we provide medical questions and pre-arrival instructions. In total, C-COM dispatched and managed resources in 245,294 dispatched events.

We have presently have 24 fully-trained dispatchers, 4 certified call-takers, 8 call-takers and dispatchers in training, 4 supervisors, 2 training & quality improvement coordinators, 4 technicians and 4.75 management & administrative staff who support C-COM.

Over the year, Clackamas County, with your support, have been actively supporting the 911 SAVES Act which is focused on changing the federal classification of 9-1-1 Telecommunicators from an administrative classification to the “protected services” occupation through the Department of Labor. Currently, legislation is pending in both the Senate and the House of Representatives with significant sponsorship to change this classification. While we are hopeful that this legislation is signed, it has been stalled for quite some times.

Given the stalls in this federal legislation, two counties in Colorado, Arapahoe & Pitkin counties, moved forward on recognizing their local 9-1-1 employees as first responders. In response to these actions in Colorado, C-COM took a similar proclamation to our Member Board, which is comprised of 15 fire departments and 6 law enforcement agencies. This proclamation was affirmed unanimously in our March 2019 Member Board meeting.

RECOMMENDATION:
C-COM Staff recommends approval of the attached proclamation to recognize telecommunicators in Clackamas County as “first responders” and honor and celebrate National Telecommunicator Week given the important work that our employees do every day to support public safety responders and save the lives of residents in our area.

Sincerely,

Cheryl Bledsoe,
C-COM Director

RECOGNIZING 911 TELECOMMUNICATORS AS FIRST RESPONDERS IN CLACKAMAS COUNTY

WHEREAS, *Clackamas County is elevating the status of its 911 Emergency Dispatchers to First Responders in a move that outpaces a similar effort on the national level; and*

WHEREAS, *Clackamas County could not wait for the 911 Saves Act that is stalled in Congress to give our dispatchers the classification of first responders that they have earned and deserve; and*

WHEREAS, *all Emergency Telecommunicators within Clackamas County are trained in emergency medical dispatch qualifying them to offer a variety of potentially lifesaving instructions including CPR, bleeding control, choking, childbirth and airway maintenance over the telephone until paramedics arrive on the scene; and*

WHEREAS, *in 2019, Clackamas Emergency Telecommunicators gave medical guidance to over 29,000 callers and Clackamas 911 Telecommunicators were recognized for their roles in saving the lives of at least 20 people who suffered cardiac arrest in our community; and*

WHEREAS, *the Clackamas 911 User Board, made up of 15 law enforcement and fire agencies, unanimously resolved to support the 911 Saves Act and all the agencies who work with C-COM already consider them "the first, first responders" as their information and instructions are critical to keeping our residents and our field units safe.*

WHEREAS, *April 12-18, 2020, is recognized as National Public Safety Telecommunicator Week, and Clackamas County typically recognizes and appreciates the dedicated and professional work done by all 9-1-1 Telecommunicators during this week,*

NOW THEREFORE BE IT PROCLAIMED, *by the Clackamas County Board of Commissioner that 9-1-1 Telecommunicators within Clackamas County, who work at Clackamas Communications (C-COM) are hereby recognized as important First Responders who serve our community.*

Dated this 16th Day of April, 2020

CLACKAMAS COUNTY BOARD OF COMMISSIONERS

Jim Bernard, Chair
Commissioner

Sonya Fischer
Commissioner

Ken Humberston
Commissioner

Paul Savas
Commissioner

Martha Schrader
Commissioner

Health, Housing & Human Services
CLACKAMAS COUNTY

Richard Swift
Director

April 16, 2020

Housing Authority Board of Commissioners
Clackamas County

Members of the Board:

Public Hearing on the Proposed 2020-2021 Housing Authority of Clackamas County Annual Plan

Purpose/Outcomes	A Public Hearing before the Housing Authority Board of Commissioners to review the past performance and to review the Proposed 2020-2021 Annual Plan
Dollar Amount and Fiscal Impact	$14,500,000 for Section 8 Voucher funds, $1,875,000 in Public Housing funds and $1,160,000 in Capital Grants Program funds
Funding Source	U.S. Department of Housing and Urban Development No County General Funds are involved.
Duration	Effective July 1, 2020 through June 30, 2021
Previous Board Action	2019-2020 Annual Plan approved by the HACC Board on April 4, 2019 – Resolution No. 1937
Strategic Plan Alignment	1. Ensure safe, healthy and secure communities 2. Build public trust through good government
Contact Person	Jill Smith, HACC Executive Director (503) 742-5336
Contract No.	N/A

BACKGROUND:
The Housing Authority of Clackamas County (HACC), a Division of the Health, Housing and Human Services Department requests a Public Hearing before the HACC Board to present HACC's policy changes, new goals and activities, progress on meeting goals and allow for public comment. This hearing will satisfy a U.S. Department of Housing and Urban Development (HUD) requirement that the public be given an opportunity annually to review the performance of the Housing Authority of Clackamas County and comment on the goals and objectives of the Annual Plan.

HACC's Annual Plan implements the goals and objectives of the 5-Year plan and updates HUD regarding the Housing Authority's policies, rules, and requirements concerning its operations, programs, and services.

Capital Fund Program (CFP) is a grant that HUD provides for the development, modernization, and management of Public Housing. HACC is applying for and seeking Capital Funds in the amount of $1,160,000 for 2020-21.

The Plan meets the following requirements of the Quality Housing and Work Responsibility Act (QHWRA) of 1998.

- The Annual Plan was developed in consultation with the Resident Advisory Board (RAB).
- The RAB is made up of residents from Public Housing and Section 8 programs. The RAB met on January 16th, 2020 to review the Plan.
- A summary of the policy changes were given to members of the RAB to distribute to their neighbors in Public Housing.
- HACC published a public notice in the Oregonian opening the Annual Plan for public review and comments from January 19, 2019 through March 5th, 2019.

- HACC published a notice in the Quarterly newsletter inviting residents to the RAB meeting, Public Hearing and notifying residents of the public review period. The Quarterly newsletter is mailed to every household living in Public Housing and emailed to families living in Section 8.
- The Plan was available at the HACC Administrative Office, HACC Property Management Offices, Clackamas County Oak Grove Library, and was posted on HACC's website.

The Public Hearing will consist of three parts:

1) A review of the past performance of the Housing Authority of Clackamas County;
2) A review of the Proposed 2020-2021 HACC Annual Plan; and
3) An open discussion period during which citizens may testify on the plan or HACC's programs and actions.

RECOMMENDATION:
Staff recommends that the HACC Board take the following actions:

1) Hold a Public Hearing to review past performance of the Housing Authority of Clackamas County and to review the proposed 2020-2021 Annual Plan;
2) Direct Housing Authority staff to make any changes necessary as a result of the Board's consideration of testimony to the Proposed Plan, and prepare for Board approval of the Final 2020-2021 Annual Plan; and
3) Place approval of the 2020-2021 Annual Plan on the HACC Board consent agenda for adoption at a special meeting scheduled for April 30, 2020.

Respectfully submitted,

Richard Swift, Director
Health, Housing and Human Services

Attachments:

- Proposed 2020-2021 Annual Plan

Housing Authority of Clackamas County (HACC)

Annual Plan
2020-2021

HACC Executive Director
Jill Smith

Housing Authority of Clackamas County

Annual Plan 2020-2021

Effective Dates July 1, 2020 – June 30, 2021

Housing Authority of Clackamas County

Annual Plan 2020-2021

Table of Contents

Streamlined Annual PHA Plan *(High Performer PHAs)*	U.S. Department of Housing and Urban Development Office of Public and Indian Housing	OMB No. 2577-0226 Expires: 02/29/2016

Purpose. The 5-Year and Annual PHA Plans provide a ready source for interested parties to locate basic PHA policies, rules, and requirements concerning the PHA's operations, programs, and services, and informs HUD, families served by the PHA, and members of the public of the PHA's mission, goals and objectives for serving the needs of low- income, very low- income, and extremely low- income families

Applicability. Form HUD-50075-HP is to be completed annually by **High Performing PHAs**. PHAs that meet the definition of a Standard PHA, Troubled PHA, HCV-Only PHA, Small PHA, or Qualified PHA do not need to submit this form.

Definitions.

(1) ***High-Performer PHA*** – A PHA that owns or manages more than 550 combined public housing units and housing choice vouchers, and was designated as a high performer on both of the most recent Public Housing Assessment System (PHAS) and Section Eight Management Assessment Program (SEMAP) assessments.

(2) ***Small PHA*** - A PHA that is not designated as PHAS or SEMAP troubled, or at risk of being designated as troubled, and that owns or manages less than 250 public housing units and any number of vouchers where the total combined units exceeds 550.

(3) ***Housing Choice Voucher (HCV) Only PHA*** - A PHA that administers more than 550 HCVs, was not designated as troubled in its most recent SEMAP assessment, and does not own or manage public housing.

(4) ***Standard PHA*** - A PHA that owns or manages 250 or more public housing units and any number of vouchers where the total combined units exceeds 550, and that was designated as a standard performer in the most recent PHAS or SEMAP assessments.

(5) ***Troubled PHA*** - A PHA that achieves an overall PHAS or SEMAP score of less than 60 percent.

(6) ***Qualified PHA*** - A PHA with 550 or fewer public housing dwelling units and/or housing choice vouchers combined, and is not PHAS or SEMAP troubled.

A. PHA Information.

A.1

PHA Name: Housing Authority of Clackamas County **PHA Code**: OR001
PHA Type: ☐ Small ☒ High Performer
PHA Plan for Fiscal Year Beginning: (MM/YYYY): 07/2020
PHA Inventory (Based on Annual Contributions Contract (ACC) units at time of FY beginning, above)
Number of Public Housing (PH) Units 545 **Number of Housing Choice Vouchers (HCVs)** 1817 **Total Combined** 2362
PHA Plan Submission Type: ☒ Annual Submission ☐ Revised Annual Submission

Availability of Information. In addition to the items listed in this form, PHAs must have the elements listed below readily available to the public. A PHA must identify the specific location(s) where the proposed PHA Plan, PHA Plan Elements, and all information relevant to the public hearing and proposed PHA Plan are available for inspection by the public. Additionally, the PHA must provide information on how the public may reasonably obtain additional information of the PHA policies contained in the standard Annual Plan, but excluded from their streamlined submissions. At a minimum, PHAs must post PHA Plans, including updates, at each Asset Management Project (AMP) and main office or central office of the PHA. PHAs are strongly encouraged to post complete PHA Plans on their official website. PHAs are also encouraged to provide each resident council a copy of their PHA Plans.

PHA Plan, PHA Plan Elements, and Public Hearing Information can be found at the following locations:
1) Housing Authority Administrative Office, 13930 S Gain Street, Oregon City, OR 97045
2) Housing Authority Clackamas Heights Property Management Office, 13900 S Gain Street, Oregon City, OR 97045
3) Housing Authority Hillside Property Management Office, 2889 Hillside Court, Milwaukie, OR 97222
4) Housing Authority Website: http://www.clackamas.us/housingauthority/plansandreports.html
5) Clackamas County Public Library located at 16201 S.E. Mcloughlin, Oak Grove, OR 97222
6) Resident Advisory Boards (RAB) Members receive a hard copy of the full draft Annual Plan
7) RAB Members receive a summary of policy changes (hard copy) to hand out to other residents.
8) The summary of policy changes is emailed out to everyone and made available on our website

☐ **PHA Consortia**: (Check box if submitting a Joint PHA Plan and complete table below)

Participating PHAs	PHA Code	Program(s) in the Consortia	Program(s) not in the Consortia	No. of Units in Each Program	
				PH	HCV
Lead PHA:					

B. Annual Plan Elements

B.1 **Revision of PHA Plan Elements.**

(a) Have the following PHA Plan elements been revised by the PHA since its last **Annual PHA Plan** submission?

Y N

☒ ☐ Statement of Housing Needs and Strategy for Addressing Housing Needs (See Attachment C)
☒ ☐ Deconcentration and Other Policies that Govern Eligibility, Selection, and Admissions (See Attached A, B, and D)
☐ ☒ Financial Resources
☒ ☐ Rent Determination (See Attachment A and B)
☐ ☒ Homeownership Programs
☐ ☒ Safety and Crime Prevention
☐ ☒ Pet Policy
☐ ☒ Substantial Deviation
☐ ☒ Significant Amendment/Modification

(b) The PHA must submit its Deconcentration Policy for Field Office Review. See Attachment D

(c) If the PHA answered yes for any element, describe the revisions for each element below: See Attachments referenced above

B.2 **New Activities.**

(a) Does the PHA intend to undertake any new activities related to the following in the PHA's current Fiscal Year?

Y N

☐ ☒ Hope VI or Choice Neighborhoods.
☒ ☐ Mixed Finance Modernization or Development
☒ ☐ Demolition and/or Disposition
☒ ☐ Conversion of Public Housing to Tenant Based Assistance (Section 18 Demolition/Disposition)
☒ ☐ Conversion of Public Housing to Project-Based Assistance under RAD
☒ ☐ Project Based Vouchers
☒ ☐ Units with Approved Vacancies for Modernization
☐ ☒ Other Capital Grant Programs (i.e., Capital Fund Community Facilities Grants or Emergency Safety and Security Grants)

(b) If any of these activities are planned for the current Fiscal Year, describe the activities. For new demolition activities, describe any public housing development or portion thereof, owned by the PHA for which the PHA has applied or will apply for demolition and/or disposition approval under section 18 of the 1937 Act under the separate demolition/disposition approval process. If using Project-Based Vouchers (PBVs), provide the projected number of project based units and general locations, and describe how project basing would be consistent with the PHA Plan.

In 2018, HACC submitted a Section 18 Disposition application for Oregon City View Manor, a 100-unit Public Housing property located at 200 S. Longview Way, Oregon City. HACC plans to continue seeking a Section 18 Disposition for this site in 2020-2021. If approved, HACC will relocate all 100 households using Section 8 vouchers and the assistance of a relocation contractor. In addition, HACC plans to explore the feasibility of submitting a Rental Administration Demonstration (RAD) or Section 18 and RAD blended application as an alternative process for this property in 2020-2021.

In 2018, HACC prepared and submitted a grant to Metro to develop a community plan for the redevelopment of the Clackamas Heights property, a 100-unit Public Housing property located at 13900 S. Gain St., Oregon City, OR 97045. HACC plans to explore the feasibility of submitting a Section 18, Straight RAD or Section 18 and RAD blended application as an alternative process for this property in 2020-2021.

HACC submitted a RAD application for our Hillside Park project consisting of a 100-unit Public Housing property located in Milwaukie. The application was approved and the PHA received the CHAP on April 26, 2019. HACC is exploring the possibility of revising the application to utilize the Section 18 and RAD blend process instead of a straight RAD conversion. We anticipate this project may be a good candidate for a Section 18 Demolition and Disposition application and plan to pursue that application in 2020-2021. If approved, HACC will relocate all 100 households using Section 8 vouchers and the assistance of a relocation contractor. Finally, HACC is exploring the possibility of using disposition funds from the previous sale of scattered site properties to fund eligible activities related to the redevelopment of Hillside Park.
Our application for a RAD conversion and Section 18 blend, in which we convert 100 units, with 70 under a RAD HAP contract and 30 under a regular PBV contract (including 5 de minimis units that are backfilled with regular PBVs) as part of the rehabilitation of Hillside Manor, located at 2889 SE Hillside Ct, Milwaukie, was approved and the project is moving forward toward construction closing in 2nd quarter 2020. Our RAD financing plan has been submitted and we are awaiting HUD approval.

Lastly, HACC has 145 scattered sites throughout Clackamas County. We anticipate working with HUD and submitting an application to begin the process of a Section 18 Disposition and/or Demolition application for these sites in 2020. If approved, HACC will relocate all 145 households using Section 8 vouchers and the assistance of a relocation contractor.

200 PBV's were approved by HUD for new development and rehabilitation projects. Request for proposals or awards of PBV are yet to be determined based on the Metro Affordable Housing Bond, the Hillside Redevelopment Plan (in initial phase of planning) and other development projects in the very early stages that are hopefully being developed in the next five (5) years. This is consistent with the PHA Plan to modernize, redevelop and demo/disposition) as our PHA Plan is required to align with the County's Consolidated Plan, Fair Housing Plan, Action Plan and Ten-Year Plan to end homelessness.

Utilizing funds allocated to the Housing Authority from the Metro Affordable Housing Bond, HACC will expand its development capacity by hiring new staff to direct affordable housing development in the County. In addition to new staff, Metro Bond funds will be used to acquire and rehabilitate a facility located at 18000 Webster Road in Gladstone that will provide 50 units of housing for homeless and very low income individuals. As an implementing jurisdiction of the Metro Bonds, all bond resources allocated to Clackamas County will run through HACC. The goal for HACC is to support the development of at least 812 units of affordable housing throughout the eligible Metro boundary within the county. This support may include direct acquisition, development, and/or ownership by HACC or involve partnering with non-profit or for-profit developers to support the development of units throughout the eligible Metro boundary. HACC's strategy for reaching this goal is outlined in the 2019 Clackamas County Local Implementation Strategy (LIS).

HACC is receiving $1,333,000 in funding from Kaiser/Healthshare, for a pilot project. HACC will serve 80 households, with a member of the household 50+ and homeless, using HUD's definition, except if fleeing domestic violence and exiting an institution. The homeless individual will have one or more disabling conditions and/or referral from one or more systems of care/institutions. The funding will be used for rent assistance and to reduce barriers to housing. Rent assistance will be provided for twelve (12) months with the pilot lasting for two (2) years.

HACC is participating in the Permanent Supportive Housing (PSH) Development and Operational Team Technical Assistance Pilot Cohort sponsored by Oregon Housing and Community Service (OHCS). Participation in the six month Technical Assistance Pilot Cohort makes HACC eligible to apply for PSH Pilot funds to provide rental assistance and capital and services funding to support the Webster Road Redevelopment Project in Gladstone.

B.3 **Progress Report.**

Provide a description of the PHA's progress in meeting its Mission and Goals described in the PHA 5-Year Plan.

PHA Goal 1: Develop new housing units with long-term affordability for a broad range of low-income households with an emphasis on dispersal of affordable housing by:
☒ Applied for and received 15 additional VASH vouchers
☒ Applied for and received 50 additional Mainstream vouchers
☒ Applied for and received 7 New Foster to Youth Initiative (FYI) vouchers
☒ Applied for 50 Family Unification Program (FUP) Vouchers at this time awaiting to hear if awarded
☒ Continuing to leverage private and/or other public funds to create additional housing opportunities
☒ Working with a broker to acquire land for new construction of affordable housing
☒ Conducted a financial feasibility study for rehabilitation, disposition, or redevelopment of existing Public Housing properties
☒ As of 2019, our multi-phase Rental Administration Demonstration (RAD) application for the rehabilitation of Hillside Manor has been approved and the project is moving forward towards rehabilitation closing in Spring 2020. Our Rental Administration Demonstration (RAD) application for the redevelopment of Hillside Park has been submitted and we are awaiting HUD approval.
☒ Prepared and submitted a grant to Metro to develop a community plan for the Hillside Park property
☒ Prepared and submitted a grant to Metro to develop a community plan for the Clackamas Heights property
☒ Continued planning for the utilization of RAD & Demolition/Disposition Section 18 to improve & increase the number of affordable housing units
☒ Submitted a Section 18 Demo/Disposition application for Oregon City View Manor. This application is still in process with HUD.
☒ Rosewood Station is under construction with the first of six buildings scheduled for leasing in May 2019. Total affordable housing is 212 units. 20 of the units were awarded PBV.
☒ Clayton Mohr Commons Veteran's Housing project was completed and has 24 Project Based Vouchers.
☒ Northwest Housing Alternatives new campus of affordable housing was completed and includes 7 PBV units.
☒ Submitted a HUD Section 108 loan application & received loan approval to fund a variety of affordable housing projects including acquisition, new construction, and rehabilitation.
☒ Acquired the Webster Road property in Gladstone using Metro Bond funds. Working with development team to rehabilitate and redevelop the property to provide up to 50 units serving low income and homeless individuals 55+ and older. HACC plans to apply for Metro Housing Bonds, LIHTC, PSH pilot funds, PBVs, and HOME funds to support redevelopment efforts.
☒ Participating in the Permanent Supportive Housing (PSH) Development and Operational Team Technical Assistance Pilot Cohort sponsored by OHCS. Participation in the six month Technical Assistance Pilot Cohort will allow HACC to apply for PSH Pilot funds to provide rental assistance and capital and services funding to support the Webster Road Redevelopment Project in Gladstone.

Housing Authority of Clackamas County certifies that the RAD conversion complies with all applicable site selection and neighborhood reviews standards and that all appropriate procedures have been followed.

PHA Goal 2: Improve access & housing choice for everyone, with a focus on protected classes and single parent households by:
☒ Provided voucher mobility counseling
☒ Conducted outreach efforts to potential voucher landlords
☒ Revised payment standards to reduce the barriers to finding affordable housing
☒ Continuing our security deposit loan program for Section 8 families
☒ Provided higher payment standards for families needing ADA units.
☒ Maintain a list of ADA units within the County to assist families seeking housing

PHA Goal 3: Enforce Fair Housing Laws and Increase public understanding of Fair Housing laws by:
☒ HACC hosted free Fair Housing and Landlord Tenant Law trainings and plans to continue hosting free training
☒ Strengthened the partnership with Fair Housing Council of Oregon and continued distributing fair housing information
☒ Continued to partner with Housing Rights & Resources Program
☒ We offer training at Metro Multifamily and other Landlord Group Meetings on the Benefits of Rental Assistance
☒ Distributed Fair Housing Videos and Information to landlords participating in Section 8 through Landlord newsletter.
☒ Continuing to educate clients on Fair Housing Rights & provide Fair Housing brochures at Orientation meetings
☒ Continued attending State subcommittee meetings on Renters Rights and other nonprofit Renter Rights Advocacy Groups
☒ Aligned our 5-year plan with the County's 5-year Consolidated Plan & completed the Assessment of Fair Housing plan
☒ Closed and completed all FHEO findings
☒ Conduct trainings for staff on Fair Housing and Diversity Equity and Inclusion

PHA Goal 4: Improve the quality of Housing Authority assisted housing and customer service by:
☒ Maintained high performer status in Section 8
☒ Improved the physical environment in our public offices
☒ Streamlined administrative operations, creating efficiencies and improving customer service
☒ Maintain a robust client feedback system to gauge if improvements are needed
☒ Completed 76 capital fund rehabilitation projects. Three (3) of the 76 projects were substantial rehabilitations averaging $125,000 per unit

	☒ Prepared and submitted a multi-phase Rental Administration Demonstration (RAD) application for the rehabilitation of Hillside Manor and the redevelopment of Hillside Park. ☒ Developed strategies for cross training staff to ensure we provide the highest level of service to clients we serve ☒ Attend RAD & LIHTC Compliance Trainings for new developments scheduled to come on line in 2020. ☒ Staff training on Diversity, Equity and Inclusion (DEI) via Meyer Memorial Trust Grant, required Mental Health First Aid Training of all staff, Trauma Informed Care training, Domestic Violence Training and Fair Housing Training. PHA Goal 5: Improve community quality of life and economic vitality by: ☒ Partnered with social service agencies to provide services to school aged youth ☒ Developed stronger partnerships with service providers who assist our elderly and/or disabled residents ☒ Continued to grow the community gardens program ☒ Encouraged Resident participation through Resident Associations ☒ Contracted with Clackamas County social services and other resident service providers to provide a variety of Public housing services using county provided general fund. ☒ Completed a Metro Grant to assist in the planning of the Hillside Park redevelopment, envisioned to be a mixed income community offering a variety of housing opportunities along a spectrum of affordability. PHA Goal 6: Promote self-sufficiency and asset development of families and individuals by: ☒ Continue to partner with local & regional workforce partners to increase the number of employed/under-employed persons in assisted housing ☒ Partnered with agencies to provide supportive services to increase independence for the elderly and families with disabilities ☒ Awarded Resident Opportunities Self Sufficiency (ROSS) grant ☒ Applied for and received renewal funding for the Family Self Sufficiency (FSS) grant ☒ Research and apply for future grants that provide services and enhance residents' quality of life ☒ Awarded a grant to implement a new credit building program for Public Housing residents. ☒ Established Memorandum of Understandings with area service agencies to provide outreach and housing stabilization services for families referred for Housing Choice Vouchers and Mainstream Vouchers. ☒ This year we implemented a new Credit Building Program for our Public Housing residents. If residents elect to enroll, HACC reports on-time rent payment, to the Credit Bureau's through a third party. This has been an effective way to support residents in their goals of becoming more financial stable and self-sufficient.
B.4.	**Most Recent Fiscal Year Audit**. (a) Were there any findings in the most recent FY Audit? Y N ☐ ☒ (b) If yes, please describe:
	Other Document and/or Certification Requirements.
C.1	**Certification Listing Policies and Programs that the PHA has Revised since Submission of its Last Annual Plan** Form 50077-ST-HCV-HP, *Certification of Compliance with PHA Plans and Related Regulations,* must be submitted by the PHA as an electronic attachment to the PHA Plan.
C.2	**Civil Rights Certification.** Form 50077-ST-HCV-HP, *Certification of Compliance with PHA Plans and Related Regulations,* must be submitted by the PHA as an electronic attachment to the PHA Plan.
C.3	**Resident Advisory Board (RAB) Comments.** (a) Did the RAB(s) provide comments to the PHA Plan? Y N ☒ ☐ If yes, comments must be submitted by the PHA as an attachment to the PHA Plan. PHAs must also include a narrative describing their analysis of the RAB recommendations and the decisions made on these recommendations.
C.4	**Certification by State or Local Officials.** Form HUD 50077-SL, *Certification by State or Local Officials of PHA Plans Consistency with the Consolidated Plan*, must be submitted by the PHA as an electronic attachment to the PHA Plan.
D	**Statement of Capital Improvements**. Required in all years for all PHAs completing this form that administer public housing and receive funding from the Capital Fund Program (CFP).
D.1	**Capital Improvements.** Include a reference here to the most recent HUD-approved 5-Year Action Plan (HUD-50075.2) and the date that it was approved by HUD. See HUD Form 50075.2 approved by HUD on 10/04/2018.

Instructions for Preparation of Form HUD-50075-HP
Annual Plan for High Performing PHAs

A. PHA Information. All PHAs must complete this section.

A.1 Include the full **PHA Name**, **PHA Code**, **PHA Type**, **PHA Fiscal Year Beginning** (MM/YYYY), **PHA Inventory, Number of Public Housing Units and or Housing Choice Vouchers (HCVs), PHA Plan Submission Type**, and the **Availability of Information**, specific location(s) of all information relevant to the public hearing and proposed PHA Plan. (24 CFR §903.23(4)(e))

PHA Consortia: Check box if submitting a Joint PHA Plan and complete the table. (24 CFR §943.128(a))

B. Annual Plan.

B.1 Revision of PHA Plan Elements. PHAs must:

Identify specifically which plan elements listed below that have been revised by the PHA. To specify which elements have been revised, mark the "yes" box. If an element has not been revised, mark "no."

☐ **Statement of Housing Needs and Strategy for Addressing Housing Needs.** Provide a statement addressing the housing needs of low-income, very low-income and extremely low-income families and a brief description of the PHA's strategy for addressing the housing needs of families who reside in the jurisdiction served by the PHA. The statement must identify the housing needs of (i) families with incomes below 30 percent of area median income (extremely low-income), (ii) elderly families and families with disabilities, and (iii) households of various races and ethnic groups residing in the jurisdiction or on the waiting list based on information provided by the applicable Consolidated Plan, information provided by HUD, and other generally available data. The identification of housing needs must address issues of affordability, supply, quality, accessibility, size of units, and location. For years in which the PHA's 5-Year PHA Plan is also due, this information must be included only to the extent it pertains to the housing needs of families that are on the PHA's public housing and Section 8 tenant-based assistance waiting lists. 24 CFR §903.7(a)(1) and 24 CFR §903.12(b). Provide a description of the PHA's strategy for addressing the housing needs of families in the jurisdiction and on the waiting list in the upcoming year. For years in which the PHA's 5-Year PHA Plan is also due, this information must be included only to the extent it pertains to the housing needs of families that are on the PHA's public housing and Section 8 tenant-based assistance waiting lists. 24 CFR §903.7(a)(2)(ii) and 24 CFR §903.12(b).

☐ **Deconcentration and Other Policies that Govern Eligibility, Selection and Admissions**. Describe the PHA's admissions policy for deconcentration of poverty and income mixing of lower-income families in public housing. The Deconcentration Policy must describe the PHA's policy for bringing higher income tenants into lower income developments and lower income tenants into higher income developments. The deconcentration requirements apply to general occupancy and family public housing developments. Refer to 24 CFR §903.2(b)(2) for developments not subject to deconcentration of poverty and income mixing requirements. 24 CFR §903.7(b) Describe the PHA's procedures for maintaining waiting lists for admission to public housing and address any site-based waiting lists. 24 CFR §903.7(b) A statement of the PHA's policies that govern resident or tenant eligibility, selection and admission including admission preferences for both public housing and HCV. (24 CFR §903.7(b) Describe the unit assignment policies for public housing. 24 CFR §903.7(b)

☐ **Financial Resources.** A statement of financial resources, including a listing by general categories, of the PHA's anticipated resources, such as PHA operating, capital and other anticipated Federal resources available to the PHA, as well as tenant rents and other income available to support public housing or tenant-based assistance. The statement also should include the non-Federal sources of funds supporting each Federal program, and state the planned use for the resources. (24 CFR §903.7(c)

☐ **Rent Determination.** A statement of the policies of the PHA governing rents charged for public housing and HCV dwelling units, including applicable public housing flat rents, minimum rents, voucher family rent contributions, and payment standard policies. (24 CFR §903.7(d) – Attachments A and B show changes in policies affecting rent determination.

☐ **Homeownership Programs**. A description of any homeownership programs (including project number and unit count) administered by the agency or for which the PHA has applied or will apply for approval. For years in which the PHA's 5-Year PHA Plan is also due, this information must be included only to the extent that the PHA participates in homeownership programs under section 8(y) of the 1937 Act. (24 CFR §903.7(k) and 24 CFR §903.12(b).

☐ **Safety and Crime Prevention (VAWA).** A description of: **1)** Any activities, services, or programs provided or offered by an agency, either directly or in partnership with other service providers, to child or adult victims of domestic violence, dating violence, sexual assault, or stalking; **2)** Any activities, services, or programs provided or offered by a PHA that helps child and adult victims of domestic violence, dating violence, sexual assault, or stalking, to obtain or maintain housing; and **3)** Any activities, services, or programs provided or offered by a public housing agency to prevent domestic violence, dating violence, sexual assault, and stalking, or to enhance victim safety in assisted families. (24 CFR §903.7(m)(5))

☐ **Pet Policy.** Describe the PHA's policies and requirements pertaining to the ownership of pets in public housing. (24 CFR §903.7(n))

☐ **Substantial Deviation.** PHA must provide its criteria for determining a "substantial deviation" to its 5-Year Plan. (24 CFR §903.7(r)(2)(i)

☐ **Significant Amendment/Modification**. PHA must provide its criteria for determining a "Significant Amendment or Modification" to its 5-Year and Annual Plan. Should the PHA fail to define 'significant amendment/modification', HUD will consider the following to be 'significant amendments or modifications': a) changes to rent or admissions policies or organization of the waiting list; b) additions of non-emergency public housing CFP work items (items not included in the current CFP Annual Statement or CFP 5-Year Action Plan); or c) any change with regard to demolition or disposition, designation, homeownership programs or conversion activities. See guidance on HUD's website at: Notice PIH 1999-51. (24 CFR §903.7(r)(2)(ii)

If any boxes are marked "yes", describe the revision(s) to those element(s) in the space provided.

PHAs must submit a Deconcentration Policy for Field Office review. For additional guidance on what a PHA must do to deconcentrate poverty in its development and comply with fair housing requirements, see 24 CFR 903.2. (24 CFR §903.23(b))

B.2 New Activities. If the PHA intends to undertake any new activities related to these elements or discretionary policies in the current Fiscal Year, mark "yes" for those elements, and describe the activities to be undertaken in the space provided. If the PHA does not plan to undertake these activities, mark "no."

☐ **Hope VI.** 1) A description of any housing (including project name, number (if known) and unit count) for which the PHA will apply for HOPE VI; and **2)** A timetable for the submission of applications or proposals. The application and approval process for Hope VI is a separate process. See guidance on HUD's website at: http://www.hud.gov/offices/pih/programs/ph/hope6/index.cfm. (Notice PIH 2010-30)

☐ **Mixed Finance Modernization or Development. 1)** A description of any housing (including name, project number (if known) and unit count) for which the PHA will apply for Mixed Finance Modernization or Development; and **2)** A timetable for the submission of applications or proposals. The application and approval process for Mixed Finance Modernization or Development is a separate process. See guidance on HUD's website at: http://www.hud.gov/offices/pih/programs/ph/hope6/index.cfm. (Notice PIH 2010-30)

☐ **Demolition and/or Disposition.** Describe any public housing projects owned by the PHA and subject to ACCs (including name, project number and unit numbers [or addresses]), and the number of affected units along with their sizes and accessibility features) for which the PHA will apply or is currently pending for demolition or disposition; and (2) A timetable for the demolition or disposition. This statement must be submitted to the extent that approved and/or pending demolition and/or disposition has changed. The application and approval process for demolition and/or disposition is a separate process. See guidance on HUD's website at: http://www.hud.gov/offices/pih/centers/sac/demo_dispo/index.cfm. (24 CFR §903.7(h))

☐ **Conversion of Public Housing.** Describe any public housing building(s) (including project number and unit count) owned by the PHA that the PHA is required to convert or plans to voluntarily convert to tenant-based assistance; **2)** An analysis of the projects or buildings required to be converted; and **3)** A statement of the amount of assistance received to be used for rental assistance or other housing assistance in connection with such conversion. See guidance on HUD's website at: http://www.hud.gov/offices/pih/centers/sac/conversion.cfm. (24 CFR §903.7(j))

☐ **Project-Based Vouchers.** Describe any plans to use HCVs for new project-based vouchers. (24 CFR §983.57(b)(1)) If using project-based vouchers, provide the projected number of project-based units and general locations, and describe how project-basing would be consistent with the PHA Plan.

☐ **Other Capital Grant Programs** (i.e., Capital Fund Community Facilities Grants or Emergency Safety and Security Grants).

B.3 Progress Report. For all Annual Plans following submission of the first Annual Plan, a PHA must include a brief statement of the PHA's progress in meeting the mission and goals described in the 5-Year PHA Plan. (24 CFR §903.7(r)(1))

B.4 Most Recent Fiscal Year Audit. If the results of the most recent fiscal year audit for the PHA included any findings, mark "yes" and describe those findings in the space provided. (24 CFR §903.7(p))

C. Other Document and/or Certification Requirements

C.1 Certification Listing Policies and Programs that the PHA has Revised since Submission of its Last Annual Plan. Provide a certification that the following plan elements have been revised, provided to the RAB for comment before implementation, approved by the PHA board, and made available for review and inspection by the public. This requirement is satisfied by completing and submitting form HUD-50077 SM-HP.

C.2 Civil Rights Certification. Form HUD-50077 SM-HP, *PHA Certifications of Compliance with the PHA Plans and Related Regulation*, must be submitted by the PHA as an electronic attachment to the PHA Plan. This includes all certifications relating to Civil Rights and related regulations. A PHA will be considered in compliance with the AFFH Certification if: it can document that it examines its programs and proposed programs to identify any impediments to fair housing choice within those programs; addresses those impediments in a reasonable fashion in view of the resources available; works with the local jurisdiction to implement any of the jurisdiction's initiatives to affirmatively further fair housing; and assures that the annual plan is consistent with any applicable Consolidated Plan for its jurisdiction. (24 CFR §903.7(o))

C.3 Resident Advisory Board (RAB) comments. If the RAB provided comments to the annual plan, mark "yes," submit the comments as an attachment to the Plan and describe the analysis of the comments and the PHA's decision made on these recommendations. (24 CFR §903.13(c), 24 CFR §903.19)

C.4 Certification by State or Local Officials. Form HUD-50077-SL, *Certification by State or Local Officials of PHA Plans Consistency with the Consolidated Plan*, must be submitted by the PHA as an electronic attachment to the PHA Plan. (24 CFR §903.15)

D. Statement of Capital Improvements

D. Statement of Capital Improvements. PHAs that receive funding from the Capital Fund Program (CFP) must complete this section. (24 CFR 903.7 (g))

D.1 Capital Improvements. In order to comply with this requirement, the PHA must reference the most recent HUD approved Capital Fund 5 Year Action Plan. PHAs can reference the form by including the following language in Section C. 8.0 of the PHA Plan Template: "See HUD Form 50075.2 approved by HUD on XX/XX/XXXX."

ATTACHMENT A

Summary of Proposed Housing Choice Voucher Administrative Plan Policy Changes Effective Upon Board Approval

Chapter	Old Policy Language	New Policy Language	Summary
3 Page 3-2	**3-I.B. FAMILY AND HOUSEHOLD [24 CFR 982.201(c); FR Notice 02/03/12, and Notice PIH 2014-20]** HACC Policy A family also includes Single-person Family: A single person who is 62 years old of age or over; or a single person who is disabled; or a single person who is displaced; or a single person who is in the process of securing legal custody of any individual under the age of 18 years; or a single woman who is pregnant. All other single persons may apply but will not be housed until all above listed single persons are housed.	**3-I.B. FAMILY AND HOUSEHOLD [24 CFR 982.201(c); FR Notice 02/03/12, and Notice PIH 2014-20]** HACC Policy **Single-person Family:** A single person who is 62 years old of age or over; or a single person who is disabled; or a single person who is displaced; or a single person who is in the process of securing legal custody of any individual under the age of 18 years; or a single woman who is pregnant. All other single persons may apply but will not be housed until all above listed single persons are housed. **A family also includes two or more individuals who are not related by blood, marriage, adoptions, other operation of law, but who either can demonstrate that they have lived together previously or certify that each individual's income and other resources will be available to meet the needs of family.** **Each family must identify the individuals to be included in the family at the time of application, and must update this information in writing if the family's composition changes**.	**Added language defining family beyond the HUD definition. Also requires that household is defined at application with only additions being for significant other or children or waiver for parents if needing care.**

4-9	**Targeted Funding [24 CFR 982.204(e)]** HUD may award a PHA funding for a specified category of families on the waiting list. HACC must use this funding only to assist the families within the specified category. In order to assist families within a targeted funding category, the PHA may skip families that do not qualify within the targeted funding category. Within this category of families, the order in which such families are assisted is determined according to the policies provided in Section 4-III.C. HACC Policy HACC administers the following types of targeted funding: • Mainstream HCV dedicated to non-elderly (must be over 18 or under 62 years of age) and disabled families. • Shelter Plus Care (SPC) grant funding which requires a client be homeless and disabled at time of application; and • VASH vouchers for qualified homeless veterans as determined by the U.S. Department of Veterans Affairs.	**Targeted Funding [24 CFR 982.204(e)] keeping all old policy and adding:** • As awarded, HACC will administer Family Unification Program (FUP) vouchers or Foster Youth to Independence (FYI) vouchers. The FUP and FYI both serve youth that the Public Child Welfare Agency (DHS) has certified to be at least 18 years old, and not more than 24 years of age, and who has left foster care, or will leave foster care within 90 days, in accordance with a transition plan described in section 475(5)(H) of the Social Security Act, and is homeless or is at risk of becoming homeless at age 16 or older. The FUP can also serve a family that DHS has certified as a family for whom the lack of adequate housing is a primary factor in the imminent placement of the family's child, or children, in/out-of-home care, or in the delay of discharge of a child, or children, to the family from out-of-home care, and that HACC has determined is eligible for a HCV. • As awarded, Metro 300 Grant for 80 elderly (age 50 and older) disabled households in housing crisis as referred by service providers who commit to no less than 24 months of housing stabilization services through a Memorandum of Understanding (MOU) with the Housing Authority.	**HACC continues to apply for new rental assistance program funding and when awarded is required to have language explaining the populations served by each funding source. Adding new funding sources**

4-11	**4-III.C. SELECTION METHOD** **Local Preferences [24 CFR 982.207; HCV p. 4-16]** 4. Families currently in the Public Housing program who have met the requirements for an emergency or administrative transfer but whose needs cannot be met within the Public Housing program through relocation **and are active applicants on the HCV wait list.**	**4-III.C. SELECTION METHOD** **Local Preferences [24 CFR 982.207; HCV p. 4-16]** 4. Families currently in the Public Housing program who have met the requirements for an emergency or administrative transfer but whose needs cannot be met within the Public Housing program through relocation.	**Removed requirement that household must already be on the HCV wait list**
4-11	**4-III.C. SELECTION METHOD** **Local Preferences [24 CFR 982.207; HCV p. 4-16]** 5. HACC Public Housing Families who are under housed or in need of reasonable accommodation that Public Housing cannot accommodate through relocation **and are already active applicants on the HCV wait list.**	**4-III.C. SELECTION METHOD** **Local Preferences [24 CFR 982.207; HCV p. 4-16]** 5. HACC Public Housing Families who are under housed or in need of reasonable accommodation that Public Housing cannot accommodate through relocation.	**Removed requirement that household must already be on the HCV wait list**
4-11	6. Maximum of 33 dedicated vouchers to serve homeless persons per fiscal year (FY) (July 1st to June 30th). Families must be homeless at time of application. This preference can only come from direct referring agencies that have signed a Memorandum of Understanding (MOU) outlining the services to be offered to those referred. The referrals should have must originated off from the Coordinated Housing Access (CHA) system and have an HMIS identification number to show an intake was completed and may include the following homeless outreach programs: Bridges to Housing (B2H), Homeless Veteran Outreach, Transitional Housing or Rapid Rehousing. These programs must	6. Maximum of 33 dedicated vouchers (in addition to all vouchers awarded by HUD to serve homeless populations) to serve homeless persons per fiscal year (FY) (July 1st to June 30th). Families must be homeless at time of application. This preference can only come from direct referring agencies that have signed a Memorandum of Understanding (MOU) outlining the services to be offered to those referred. The referrals must originate from the Coordinated Housing Access (CHA) system **and have an HMIS identification number to show an intake was completed.** To be referred households must be actively engaged in services at time of voucher issue. Vouchers will be distributed first come, first served order. Unused Preference slots do not carry over to the next fiscal year.	**Simplified and added language requiring HMIS identification number to show family originated off the CHA.**

	serve families that at time of entry met the definition of homeless and verification of that status can be provided at application. To be referred households must be actively engaged in services at time of voucher issue. Vouchers will be distributed first come, first served order. Unused Preference slots do not carry over to the next fiscal year.		
4-12	**4-III.C. SELECTION METHOD** **Local Preferences [24 CFR 982.207; HCV p. 4-16]** 8. Maximum of 10 dedicated vouchers per year within a fiscal year (July 1st to June 30th) for households referred **by a Clackamas County Continuum of Care Permanent Supportive Housing (PSH)** provider that has entered into an MOU with HACC and applicant has been deemed by the provider to be in less need for supportive services. The household must be considered a candidate that is graduating off the PSH and that at time of entry into the PSH program were homeless and/or disabled. Unused Preference slots do not carry over to the next fiscal year.	**4-III.C. SELECTION METHOD** **Local Preferences [24 CFR 982.207; HCV p. 4-16]** 8. Maximum of 10 dedicated vouchers per year within a fiscal year (July 1st to June 30th) for households referred by a provider that has entered into a Supportive Services MOU with HACC and applicant has been deemed by the provider to be in less need for supportive services. The household must be considered a candidate that is graduating off the PSH and that at time of entry into the PSH program were homeless and/or disabled. Unused Preference slots do not carry over to the next fiscal year.	**Removed requirement that must be a CoC PSH provider as this was a barrier to many SPMI clients.**
5-9	**5-II.B. DETERMINING FAMILY UNIT (VOUCHER) SIZE [24 CFR 982.402]** • A separate bedroom will be allocated for a single head of household with children. The two per bedroom will be required thereafter regardless of gender or age of the remaining household members.	**5-II.B. DETERMINING FAMILY UNIT (VOUCHER) SIZE [24 CFR 982.402]** **Delete language**	**Removed extra bedroom for single head of household with child(ren). Making Occupancy two per room regardless of age, sex, or generation.**

6 6-41	**6-II.F. CHILD CARE EXPENSE DEDUCTION** HUD defines *child care expenses* at 24 CFR 5.603(b) as –amounts anticipated to be paid by the family for the care of children under 13 years of age during the period for which annual income is computed, but only where such care is necessary to enable a family member to actively seek employment, be gainfully employed, or to further his or her education and only to the extent such amounts are not reimbursed. The amount deducted shall reflect reasonable charges for child care. In the case of child care necessary to permit employment, the amount deducted shall not exceed the amount of employment income that is included in annual income.	**6-II.F. CHILD CARE EXPENSE DEDUCTION (keeping current language and adding the following)** If the child is disabled and over age 13, HACC may consider this a disability assistance expense and refer to unreimbursed reasonable attendant care in excess of 3% of annual income (reference 5.611(a)(3)(ii)) **but only where such care is necessary to enable a family member to actively seek employment, be gainfully employed, or to further his or her education and only to the extent such amounts are not reimbursed. The amount deducted shall reflect reasonable charges for services provided in the private market.**	**Aligning this policy with Section 8 where disabled and over 13 years old children can get child care disability assistance.**
10-7	**Housing Assistance Payments [24 CFR 982.311(d)]** When a family moves out of an assisted unit, HACC may not make any housing assistance payment to the owner for any month **after** the month the family moves out. The owner may keep the housing assistance payment for the month when the family moves out of the unit.	**Housing Assistance Payments [24 CFR 982.311(d)]** When a family moves out of an assisted unit, HACC may not make any housing assistance payment to the owner for any month **after** the month the family moves out. The owner may keep the housing assistance payment for the month when the family moves out of the unit. **HACC Policy** **HACC will pursue a prorated Housing Assistance Payment (HAP) whenever possible for mid-month moves. Should a family give advance notice to vacate mid-month, only prorated rent will be paid.**	**Add language that identifies current practice used to try and save funding.**

10-7	**Zero HAP Families Who Wish to Move [24 CFR 982.455]** HACC Policy If the family voluntarily moves while at zero HAP their voucher terminates automatically. The family is choosing to move without assistance.	**Zero HAP Families Who Wish to Move [24 CFR 982.455]** **A participant who is not receiving any subsidy, but whose HAP contract is still in force, may request a voucher to move to a different unit. The PHA must issue a voucher to move unless it has grounds to deny assistance under the program regulations. However, if the PHA determines no subsidy would be paid at the new unit, the PHA may refuse to enter into a HAP contract on behalf of the family.** **HACC Policy** **If a zero HAP family requests to move to a new unit, the family may request a voucher to move. However, if no subsidy will be paid at the unit to which the family requests to move, the PHA will not enter into a HAP contract on behalf of the family for the new unit.**	**Required change for compliance which allows Zero HAP families to move with assistance if subsidy would be paid at new unit.**

11-11	*Required Reporting Remained Unchanged* HUD regulations give HACC the freedom to determine the circumstances under which families will be required to report changes affecting income. HACC Policy Families are required to report all increases in income (including new employment or change of employment), and assets within 7 business days of the date the change takes effect. The PHA will only conduct interim examinations that result in an increase in income under the following circumstances: 1) For families that qualify for the earned income disallowance (EID), and only when the EID family's share of rent will change as a result of the increase. 2) For families participating in the FSS program when the increase is due to an increase in earned income that will result in an increase in escrow credit. 3) When changes in income have not been reported to the PHA in a timely manner (within 7 business days of the change). In this situation, the PHA will conduct an interim reexamination and will make the change in tenant rent retroactive to the first of the month following the month when the change occurred. The family will be required to enter into a repayment agreement with the PHA for the overpaid assistance. 4) When the family previously had been at zero income. In all other cases, the PHA will note the information in the tenant file, but will not conduct an interim reexamination.	*RAB Notification of Midyear Change not Done* **Mid-Year Change was not adopted, HACC continues to administer per HACC policy in column one.**	**Notifying RAB that a midyear change was not adopted, pending HUD regulatory direction.**
16-4	**Updating Payment Standards**	**Updating Payment Standards** **HACC may establish multiple payment standards by area to encourage lease up in low poverty census tracts. Area payment standards may need to apply for exception payment standards if needed to ensure the success of deconcentrating poverty.**	**Adding language so HACC can establish payment standard by area.**

16-4	None	**Voluntary Use of Small Area FMRs [24 CFR 982.503, Notice PIH 2018-01]** **PHAs that administer vouchers in a metropolitan area where the adoption of small area FMRs (SAFMRs) is not required may request approval from HUD to voluntarily adopt SAFMRs. SAFMRs may be voluntarily adopted for one or more zip code areas.** **HACC Policy** **HACC will not voluntarily adopt the use of SAFMRs.**	**Adding required language and made decision to not adopt SAFMRs**
17-36	**17-VIII.B. RENT LIMITS [24 CFR 983.301]** **HACC Policy** HACC's goal is to provide as many families with vouchers as possible. Given the budget limitations of the program, HACC must implement policies that control its HAP expenditures. The rent to owner must not exceed the lowest of the following amounts: • An amount determined by the PHA, not to exceed applicable payment standard for the unit bedroom size minus any utility allowance • The reasonable rent; or • The rent requested by the owner. • For PBV rent approved prior to April 1, 2019, the initial rent to owner will not fall below the subsidy layering review initial approved rent by HUD.	**17-VIII.B. RENT LIMITS [24 CFR 983.301]** **HACC Policy** HACC's goal is to provide as many families with vouchers as possible. Given the budget limitations of the program, HACC must implement policies that control its HAP expenditures. The rent to owner must not exceed the lowest of the following amounts: • An amount determined by the PHA, not to exceed applicable payment standard for the unit bedroom size minus any utility allowance • **For projects serving homeless or other high needs population requiring permanent supportive housing that would require the increase, not to exceed 110% of FMR;** • The reasonable rent; or • The rent requested by the owner. • For PBV rent approved prior to April 1, 2019, the initial rent to owner will not fall below the subsidy layering review initial approved rent by HUD.	**Added language to allow properties that serve disabled populations with services on site 110% of FMR.**

ATTACHMENT B

Summary of Proposed Admissions & Continued Occupancy Plan Policy Changes

Effective upon Board Approval

Chapter	Old Policy Language	New Policy Language	Summary
3 Page 3-2	**3-I.B. FAMILY AND HOUSEHOLD [24 CFR 5.105(a)(2), 24 CFR 5.403, FR Notice 02/03/12, and Notice PIH 2014-20]** HACC Policy A family also includes Single-person Family: A single person who is 62 years old of age or over; or a single person who is disabled; or a single person who is displaced; or a single person who is in the process of securing legal custody of any individual under the age of 18 years; or a single woman who is pregnant. All other single persons may apply but will not be housed until all above listed single persons are housed.	**3-I.B. FAMILY AND HOUSEHOLD [24 CFR 5.105(a)(2), 24 CFR 5.403, FR Notice 02/03/12, and Notice PIH 2014-20]** HACC Policy **Single-person Family**: A single person who is 62 years old of age or over; or a single person who is disabled; or a single person who is displaced; or a single person who is in the process of securing legal custody of any individual under the age of 18 years; or a single woman who is pregnant. All other single persons may apply but will not be housed until all above listed single persons are housed. **A family also includes**: Two or more individuals who are not related by blood, marriage, adoptions, other operation of law, but who either can demonstrate that they have lived together previously or certify that each individual's income and other resources will be available to meet the needs of family. Each family must identify the individuals to be included in the family at the time of application, and must update this information if the family's composition changes.	**Adding language with definition on family composition.**
3 Page 3-28	**3-III.D. SCREENING** Resources Used to Check Applicant Suitability [PH Occ GB, pp. 47-56] HACC Policy PHA and landlord references for the past **five** years, gathering information on	**3-III.D. SCREENING** Resources Used to Check Applicant Suitability [PH Occ GB, pp. 47-56] HACC Policy PHA and landlord references for the past **two** years, gathering information on whether the applicant kept	**Changing amount of time from five to two years.**

	whether the applicant kept a unit clean, safe and sanitary; whether they violated health or safety codes; whether any damage was done by the applicant to a current or previous unit or the development, and, if so, how much the repair of the damage cost; whether the applicant's housekeeping caused insect or rodent infestation; and whether the neighbors complained about the applicant or whether the police were ever called because of disturbances.	a unit clean, safe and sanitary; whether they violated health or safety codes; whether any damage was done by the applicant to a current or previous unit or the development, and, if so, how much the repair of the damage cost; whether the applicant's housekeeping caused insect or rodent infestation; and whether the neighbors complained about the applicant or whether the police were ever called because of disturbances.	
4 Page 4-2	**4-I.B. APPLYING FOR ASSISTANCE** HACC Policy When a **site based** wait list is open, between the date of application and the availability of unit, a two-step process will be used for all applications.	**Removing word site based**	**One Wait list instead of limiting options based on location and unit size.**
4 Page 4-6	**4-I.B. APPLYING FOR ASSISTANCE** HACC Policy HACC will maintain **site-based** waiting lists….	**Changing to:** HACC Policy HACC will maintain one wait list for its entire portfolio and will serve families based on Occupancy Standard and Unit Size. HACC will pull applicants based on composition that meets the vacant unit size.	**One Wait list allows families that change over time to meet get into housing that meets their needs faster not limiting locations.**
4 Page 4-6	**4-II.B. ORGANIZATION OF THE WAITING LIST** HACC Policy HACC has no Public Housing Preferences for its site based waiting lists. HACC has a Homeless preference referral only waitlist. Clackamas Coordinated Housing Access (CHA) will provide the referral for the Homeless Preference waitlist.	**4-II.B. ORGANIZATION OF THE WAITING LIST** HACC Policy HACC has a Homeless preference referral for households who have originated off the Coordinated Housing Access (CHA) system as homeless or at risk of homelessness who are being served by a service provision partner with an MOU in place with HACC to provide housing retention and other vital services.	**Removed language stating HACC does not have Preferences.** **Clarify language to state that HACC will take referral for households who have originated off the Coordinated Housing Access (CHA) system as homeless or at risk of homelessness who are being served by a service provision partner.**

4 Page 4-15	**Homeless Preference** HACC Policy HACC will administer a separate waiting list for the Homeless Preference. The list will require an applicant to be homeless at the time of application. HACC will provide 5 public housing units per fiscal year (July 1st to June 30th) for the Homeless Preference. HACC will only accept qualified applications for the Homeless Preference received by Clackamas County Coordinated Housing Access (CHA) program, in which the preliminary assessment of the family's eligibility was determined. HACC will then use the ACOP Eligibility screening criteria to determine if the referred family qualify for the Public Housing program. HACC will provide a maximum of 5 dedicated Public Housing Units per fiscal year (FY) (July 1st to June 30th) for families eligible for referrals from a HACC identified transitional housing or Rapid Rehousing (RRH) program for homeless families within Clackamas County that offer one-on-one case management for not less than 1 year following the family's exit from the referring program, have preferably had some type of RentWell or equivalent	**Homeless Preference** HACC Policy HACC will offer no more than two vacancies per Public Housing property (Clackamas Heights, OCVM and Hillside Park) per fiscal year (FY) (July 1st to June 30th) to households referred by an entity who has entered into a Memorandum of Understanding (MOU) to provide services to homeless or at risk of homelessness families who have originated off the Coordinated Housing Access (CHA) system as homeless or at risk of homelessness. Families include single member households. The MOU requires one-on-one case management for not less than 2 years following the household's successful screening and housing placement. Services provided must focus on housing stabilization and retention and may include but is not limited to: assistance with timely rental payments, assistance with timely utility payments, deposit assistance, mediation services, mental health and addiction referrals for services, Worksource and SOAR connection, and financial and budgeting education services and other services that will help the family to achieve their individual goals. Referred applicants must be willing and able to immediately enter into a lease upon successful screening. HACC will use the ACOP Eligibility screening criteria to determine if the referred family qualify for the Public Housing program.	**Updated language to show that HACC will be accepting referrals of homeless applicant or homeless exiting from a program in which they were homeless at entry.**

training, and must pass HACC screening criteria.

These families will be served on a first come, first serve basis on date and time of placement on the preference wait list. Unused Preference slots do not carry over to the next fiscal year. To qualify, the family must be referred by a case manager of a qualified RRH program or Transitional Housing Program within Clackamas County and be able to verify homeless status at time of entering RRH or transitional housing and case manager must offer assistance with housing related issues for not less than one year. If it is determined by HACC that the resident demonstrates a need for an additional case management the CHA will cooperate with HACC in providing case management until the household is stabilized and meets HUD Public Housing Program Regulations.

A maximum of 25 referred Applicants whom qualify for the preference will be placed on the waiting list which will be maintained by HACC. The waiting list will always remain open for those applicants who qualify for the preference and are referred by the CHA program or any other Clackamas County program whom HACC has executed a Memorandum of Understanding to provide one-on-one case management. No applicant has a right or entitlement to be listed on the waiting list, or to any particular position on the waiting list. A homeless applicant is defined as one of the following:

	1. Any family that is living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, emergency shelter); or 2. Any family that is living in a public or private place not meant for human habitation. 3. Any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence.		
4 4-15	**PLACEMENT ON THE WAITING LIST** HACC will accept each qualified application for the preference received by Clackamas County Coordinated Housing Access (CHA) program, in which the preliminary assessment of the family's eligibility was determined. Applicants whom qualify for the preference will be placed on the waiting list which will be maintained by HACC. The waiting list will always remain open for those applicants who qualify for the preference. No applicant has a right or entitlement to be listed on the waiting list, or to any particular position on the waiting list.	**Removed language**	**Homeless Preference language no longer needed as it was incorporated into the main policy.**

5 Page 5-2	**5-I.B. DETERMINING UNIT SIZE** HACC Policy • A separate bedroom will be allocated for a single head of household with children. The two per bedroom will be required thereafter regardless of gender or age of the remaining household members. **c)** A family consisting solely of a pregnant woman will be treated as a one person household;	**5-I.B. DETERMINING UNIT SIZE** **Delete language**	**Removed extra bedroom for single head of household with child(ren). This will make it 2 per bedroom regardless of age, sex, generation or any other consideration.**
5 Page 5-4	**5-I.B. DETERMINING UNIT SIZE** HACC Policy HACC has no Public Housing units larger than four-bedroom units. Should the family size increase to the point where a five-bedroom unit is required, the family will be issued a Housing Choice Voucher, if available. If the term of the voucher expires and the family still has not moved, the Housing Authority will take steps to terminate the lease agreement, unless this is waived by the Executive Director. A waiver will only be considered in the most unique of circumstances.	**5-I.B. DETERMINING UNIT SIZE** HACC Policy HACC has no Public Housing units larger than four-bedroom. Therefore, HACC must deny entry to any household larger than nine (9) family members at time of completing eligibility screening for waiting list applications.	**HACC is clarifying this policy and make it easier to understand that HACC maximum allowed number of people, which can be housed in its largest 4 bedroom unit, is 9 people.**
6 6-41	**6-II.F. CHILD CARE EXPENSE DEDUCTION** HUD defines *child care expenses* at 24 CFR 5.603(b) as –amounts anticipated to be paid by the family for the care of children under 13 years of age during the period for which annual income is computed, but only where such care is necessary to enable a family member to actively seek employment, be gainfully employed, or to	**6-II.F. CHILD CARE EXPENSE DEDUCTION (keeping current language and adding the following)** If the child is disabled and over age 13, HACC may consider this a disability assistance expense and refer to unreimbursed reasonable attendant care in excess of 3% of annual income (reference 5.611(a)(3)(ii)) but only where such	**Aligning this policy with Section 8 where disabled and over 13 years old children can get child care disability assistance.**

	further his or her education and only to the extent such amounts are not reimbursed. The amount deducted shall reflect reasonable charges for child care. In the case of child care necessary to permit employment, the amount deducted shall not exceed the amount of employment income that is included in annual income.‖	care is necessary to enable a family member to actively seek employment, be gainfully employed, or to further his or her education and only to the extent such amounts are not reimbursed. The amount deducted shall reflect reasonable charges for services provided in the private market.	
9 9-6	**9-I.D. CONDITING ANNUAL REEXAMINATIONS** **Criminal Background Checks** PHA Policy At the annual reexamination, the PHA will ask whether the tenant, or any member of the tenant's household, is subject to a lifetime sex offender registration requirement in any state. The PHA will use the Dru Sjodin National Sex Offender database to verify the information provided by the tenant.	**9-I.D. CONDITING ANNUAL REEXAMINATIONS** **Criminal Background Checks** HACC Policy At this time, HACC is asking head of household members to identify if any member of the household has been convicted of a crime in the last 12 months or if a member of your household is subject to a lifetime registration as a registered sex offender as part of the Annual recertification packet. This question will be included as part of the Annual Recertification packet. Family members age 15 and older must sign a Criminal Background release at Annual.	**We are updating the language to align it with Section 8 and the information on the annual forms.**

9 Page 9-13	**HACC-initiated Interim Reexaminations** HACC Policy HACC will conduct interim reexaminations in each of the following instances: For families receiving the Earned Income Disallowance (EID), HACC will conduct an interim reexamination at the start, to adjust the exclusion with any changes in income, and at the conclusion of the 24-month eligibility period. **If the family has reported zero income, HACC will conduct an interim reexamination every 4 months as long as the family continues to report that they have no income.**	**HACC-initiated Interim Reexaminations** HACC Policy HACC will conduct interim reexaminations in each of the following instances: For families receiving the Earned Income Disallowance (EID), HACC will conduct an interim reexamination at the start, to adjust the exclusion with any changes in income, and at the conclusion of the 24-month eligibility period.	**Reduce work load requirement of checking every quarter and family already is required to report within 7 days if there is a change of income such as employment, Social Security Award, or child support.**
9 Page 9-14	*Required Reporting* HUD regulations give HACC the discretion to determine the circumstances under which families will be required to report changes affecting income. HACC Policy Families are required to report all increases in income (including new employment or change of employment), and assets within 7 business days of the date the change takes effect. HACC will only conduct interim reexaminations that result in an increase in income under the following circumstances: 1) For families that qualify for the earned income disallowance (EID), and only when the EID family's share of rent will change as a result of the increase. 2) When changes in income have not been reported to HACC in a timely manner (within 7 business days of the change). In this situation, HACC will conduct an interim reexamination and will make the change in tenant rent retroactive to the first of the month following the month when the change occurred. The family will be required to enter into a	*Required Reporting (keeping all old language and adding the following :)* 4) For families participating in the FSS program when the increase is due to an increase in earned income that will result in an increase in escrow credit.	**Adding new language for PH newly adopted FSS program participation.**

	repayment agreement with HACC for the overpaid assistance. 3) When the family previously had been at zero income.		
13 Page 13-16	**Over-Income Families [24 CFR 960.261 and FR Notice 7/26/18; Notice PIH 2019-11]** The Housing Opportunity through Modernization Act (HOTMA) of 2016 placed an income limitation on public housing tenancies. The over-income requirement states that after a family's adjusted income has exceeded 120 percent of area median income (AMI) (or a different limitation established by the secretary) for two consecutive years, the PHA must either terminate the family's tenancy within six months of the determination, or charge the family a monthly rent that is the higher of the applicable fair market rent (FMR) or the amount of monthly subsidy for the unit, including amounts from the operating and capital funds, as determined by regulations. PHAs also have discretion, under 24 CFR 960.261, to adopt policies allowing termination of tenancy for families whose income exceeds the limit for program eligibility. Such policies would exempt families participating in the Family Self-Sufficiency (FSS) program or currently receiving the earned income disallowance.	**Over-Income Families [24 CFR 960.261 and FR Notice 7/26/18; Notice PIH 2019-11]** The Housing Opportunity through Modernization Act (HOTMA) of 2016 placed an income limitation on public housing tenancies. The over-income requirement states that after a family's adjusted income has exceeded 120 percent of area median income (AMI) (or a different limitation established by the secretary) for two consecutive years, the PHA must either terminate the family's tenancy within six months of the determination, or charge the families monthly rent to an amount that is the higher of the applicable fair market rent (FMR) or the amount of monthly subsidy for the unit, including amounts from the operating and capital funds, as determined by regulations. **Notice PIH 2019-11 also requires that PHAs publish over-income limits in their ACOP and update them no later than 60 days after HUD publishes new income limits each year. The over-income limit is calculated by multiplying the very low-income limit (VLI) by 2.4, as adjusted for family size.** PHAs also have discretion, under 24 CFR 960.261, to adopt policies allowing termination of tenancy for families whose income exceeds the limit for program eligibility. Such policies would exempt families participating in the Family Self-Sufficiency (FSS) program or currently receiving the earned income disallowance.	**HACC is choosing to terminate an over-income family. This will allow HACC to continue serving low income families who need housing.**

HACC Policy

HACC will evict or terminate the tenancies of families whose income exceeds the income limit for program eligibility as described at 24 CFR 960.261.

HACC will rely on the over-income limits as published on HACC's website https://www.clackamas.us/housingauthority/section8.html. These numbers will be updated within 60 days of HUD publishing new income limits each year and will be effective for all annual and interim reexaminations once these policies have been adopted.

Attachment C
Statement of Housing Needs and Strategy for Addressing Housing Needs

Introduction

The Housing Authority of Clackamas County (HACC) is committed to affirmatively furthering fair housing and contributing to the elimination of impediments to fair housing choice as described in 24 CFR Part 570.601 and the Furthering Fair Housing Executive Order 11063, as amended by Executive Order 12259.

Clackamas County Community Development Division (CDD) with local Fair Housing Partners participated in a Fair Housing Collaboration and completed an Assessment of Fair Housing (AFH) Plan.

Local Efforts

In preparing the AFH, CDD assembled its Fair Housing Partners to identify goals and strategies to improve housing choices in Clackamas County. CDD's Fair Housing local partners include; cities, towns and hamlets in Clackamas County, Clackamas County Social Services Division (SSD), Clackamas County Department of Transportation and Development (DTD), the Fair Housing Council of Oregon (FHCO) and Legal Aid Services of Oregon (LASO).

Six (6) general fair housing goals were identified in the AFH:

- Goal I**:** Develop new housing units with long-term affordability for a broad range of low-income households with an emphasis on dispersal of affordable housing
- Goal II: Increase accessibility to affordable housing for person with disabilities and single parent familial status households (households with children under 18 yrs.)
- Goal III: Improve access to housing and services for all protected classes
- Goal IV: Enforce Fair Housing laws and increase public understanding of Fair Housing laws
- Goal V: Coordinate Fair Housing advocacy and enforcement efforts among regional partners
- Goal VI: Ensure that all housing in Clackamas County is healthy and habitable

Regional Efforts

The AFH has been completed and was approved by HUD. Clackamas County continues to meet quarterly with regional partners to coordinate fair housing efforts, data collection, training and events. Regional partners include: Multnomah County, Washington County, Clark County (WA), City of Portland, City of Gresham, and the City of Beaverton. In addition, there are several agencies that provide fair housing service in the county, including the United States Department of Housing and Urban Development, The Fair Housing Council of Oregon, Legal Aid Services of Oregon and Clackamas County Social Services Division, Housing Rights and Resources Program.

Regional partners intend to move to a regional Analysis of Impediments to Fair Housing study and regional data collection in order to plan more effective training events and strategies to reduce housing discrimination and increase housing choice for residents in the Portland Metropolitan area housing market. Regional partners are also working to align their fair housing efforts with the public housing authorities' plans to increase access to housing.

Statewide Goals of the Fair Housing Council of Oregon:

The Fair Housing Council of Oregon (FHCO) has contracts with the state of Oregon and with several local governments to provide fair housing training to tenants and landlords. FHCO has assembled a group of fair housing partners to coordinate fair housing activities, training and events. The first meeting was held on May 6, 2014 to discuss needs for education and outreach, audit testing needs (to find out if landlords are discriminating against protected classes of people) and, other identified by local agencies. FHCO is also being asked by partners to collect and analyze housing discrimination data to report out to partners.

Oregon state laws have changed:

- Senate Bill 608: prohibits landlord from terminating month to month tenancy without cause after 12 months of occupancy. Provides exception for certain tenancies on building or lot used by landlord as residence.

Allows landlord to terminate tenancy with 90 days' written notice and payment of one month's rent under certain conditions. Exempts landlord managing four or fewer units from payment of one month's rent.

Provides that fixed term tenancy becomes month-to-month tenancy upon ending date if not renewed or terminated. Allows landlord to not renew fixed term tenancy if tenant receives three lease violation warnings within 12 months during term and landlord gives 90 days' notice. Limits rent increases for residential tenancies to one per year. Limits maximum annual rent increase to seven percent above annual change in consumer price index. Requires Oregon Department of Administrative Services to publish maximum annual rent increase percentage.

- Measure 102 https://www.opb.org/news/article/oregon-measure-102-affordable-housing-result/

Clackamas County Actions Taken in 2019-2020 and Analysis of Impact

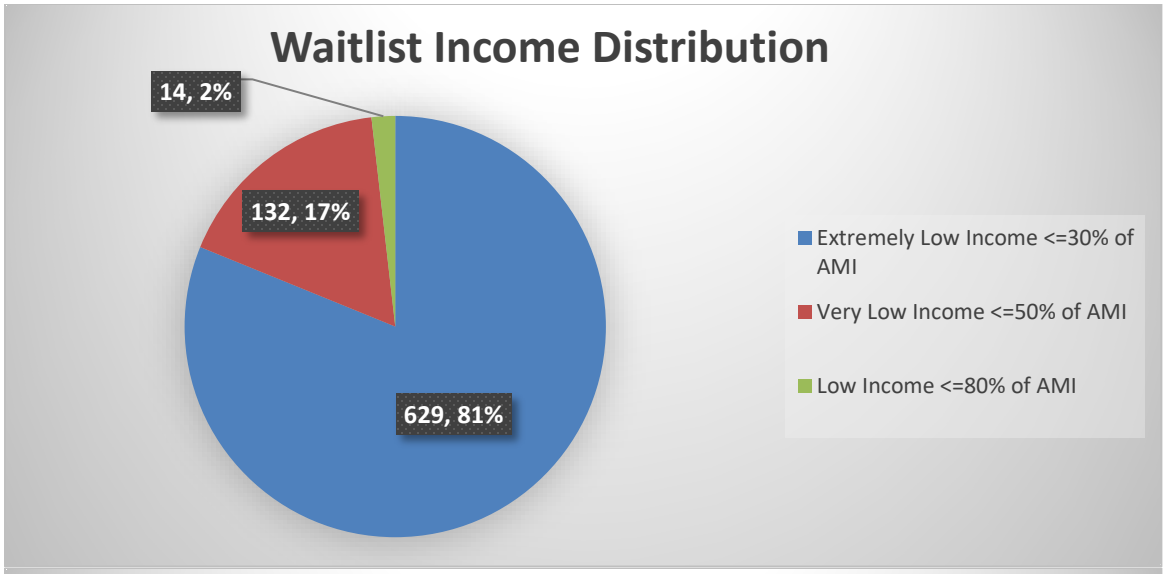
Strategy	Primary Partners (Lead in **BOLD**)	Accomplishments
Commit to countywide and regional support to continue and enhance enforcement of fair housing laws	**SSD** HACC CDD	Clackamas County Social Services Division, SSD has annual contracts with the Fair Housing Council of Oregon FHCO and Legal Aid Services of Oregon (LASO) to provide enforcement of fair housing laws. FHCO assisted 209 people with housing information. 31 (15%) were Latino and 12 (6%) were African American.
Improve access to fair housing information	SSD **CDD** HACC	Clackamas County Community Development Division, CDD has met with regional partners and the Fair Housing Council of Oregon to coordinate Fair Housing activities, develop a centralized resource and to develop fair housing materials in multiple languages and formats.
Expand opportunities for tenants using Housing Choice Vouchers	**HACC**	The Housing Authority of Clackamas County, HACC has landlord outreach materials posted on the HACC website: https://www.clackamas.us/housingauthority/landlords.html Outreach for events and trainings were done by the following: • Direct email invitations to our landlord email list • Announcements on the Metro Multi Family Calendar of events • Fair Housing Council of Oregon Announcements • Promoted on HACC Website • Word of mouth through property management companies, etc **Landlord Newsletters** continues to be distributed and posted on HACC's website.
Ensure the HACC conducts targeted outreach to underrepresented & protected class for upcoming waitlist opening	**HACC**	HACC is opening it's waiting lists in 2020 and plans to add new applicants to the Housing Choice Voucher Section 8 waitlist and several of the Public Housing waitlists.

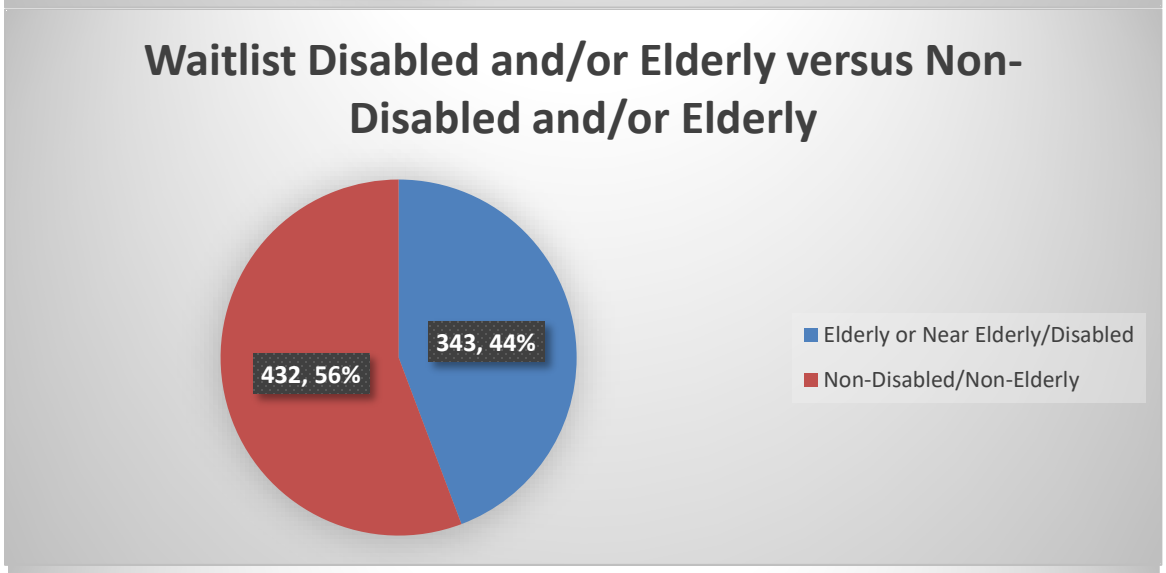
Housing Needs

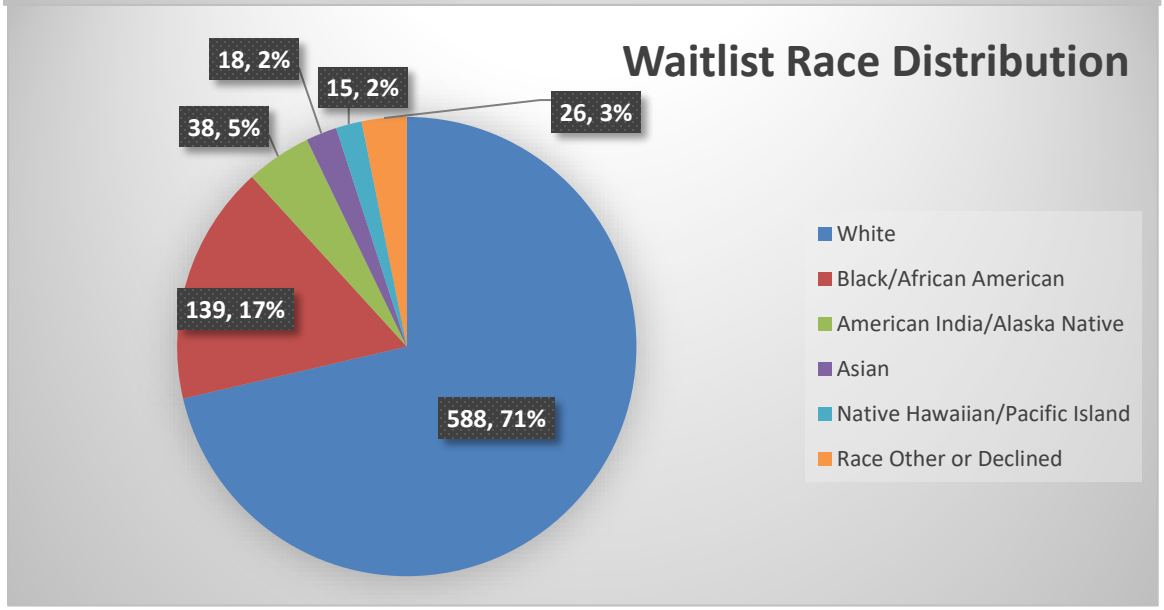
Based on information provided by the applicable Consolidated Plan, information provided by HUD, and other generally available data, make a reasonable effort to identify the housing needs of the low-income, very low-income, and extremely low-income families who reside in the jurisdiction served by the PHA, including elderly families,

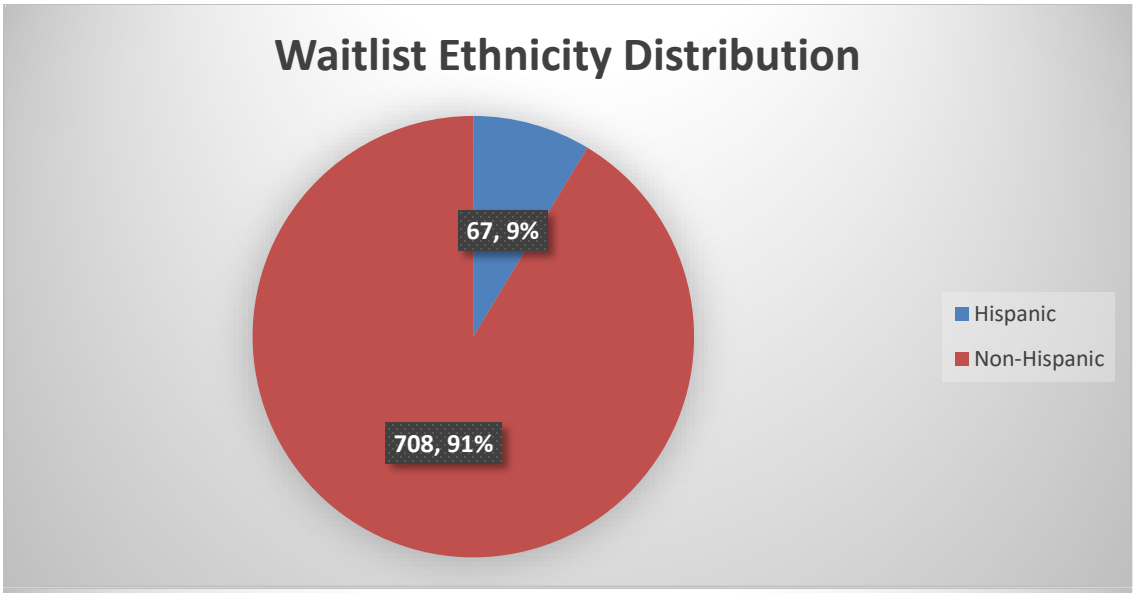
families with disabilities, and households of various races and ethnic groups, and other families who are on the public housing and Section 8 tenant-based assistance waiting lists. The identification of housing needs must address issues of affordability, supply, quality, accessibility, size of units, and location.

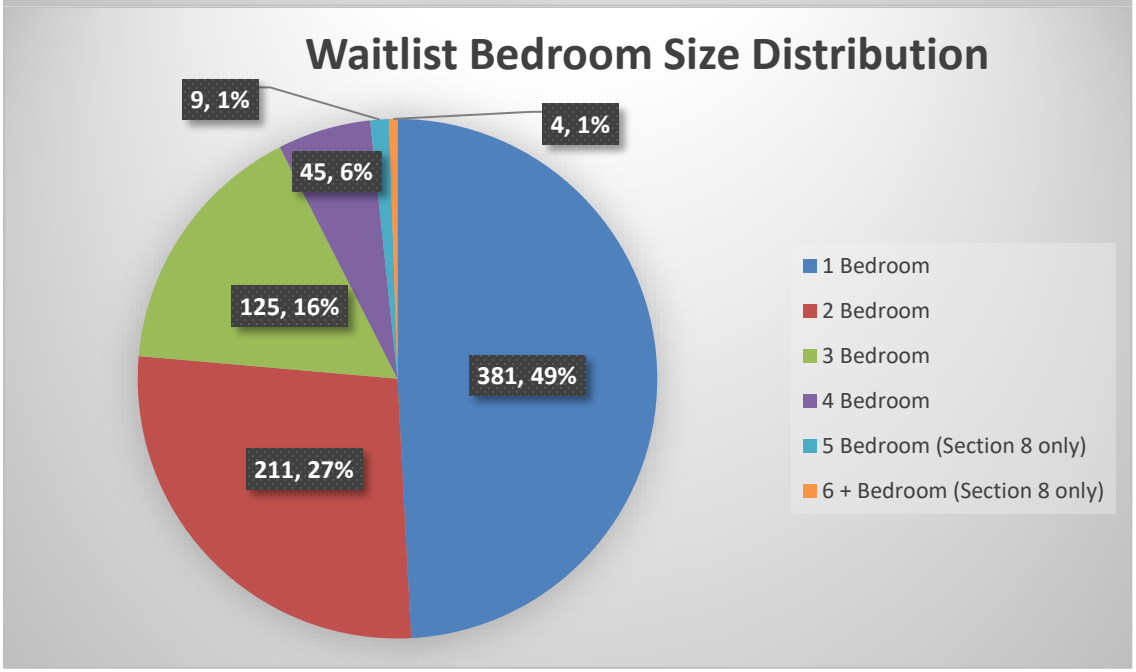
Housing Needs of Families on the Waiting List: Housing Choice Voucher and Public Housing		
	# of Families	% of Total Families
Waiting List Total	775	100%
Section 8 Waiting List	277	36%
Public Housing Waiting List	498	64%
Extremely Low Income <= 30% of AMI	629	81%
Very Low Income <= 50% of AMI	132	17%
Low Income <= 80% of AMI	14	2%
Above 80% of AMI	0	0%
Elderly or Near Elderly/Disabled	343	44%
Non-Elderly / Non-Disabled	432	56%
White	588	71%
Black/African American	139	17%
American Indian/Alaska Native	38	5%
Asian	18	2%
Native Hawaiian/Pacific Island	15	2%
Race Other or Declined	26	3%
Hispanic	67	9%
Non-Hispanic	708	91%
Characteristics by Bedroom Size		
1 BR	381	49%
2 BR	211	27%
3 BR	125	16%
4 BR	45	6%
5 BR (Section 8 only)	9	1%
6 BR (Section 8 only)	4	1%


Waitlist Income Distribution
14, 2%
132, 17%
629, 81%
Extremely Low Income <=30% of AMI
Very Low Income <=50% of AMI
Low Income <=80% of AMI


Waitlist Disabled and/or Elderly versus Non-Disabled and/or Elderly
343, 44%
432, 56%
Elderly or Near Elderly/Disabled
Non-Disabled/Non-Elderly


Waitlist Race Distribution
18, 2%
15, 2%
26, 3%
38, 5%
139, 17%
588, 71%
White
Black/African American
American India/Alaska Native
Asian
Native Hawaiian/Pacific Island
Race Other or Declined


Waitlist Ethnicity Distribution
67, 9%
708, 91%
Hispanic
Non-Hispanic


Waitlist Bedroom Size Distribution
9, 1%
4, 1%
45, 6%
125, 16%
381, 49%
211, 27%
1 Bedroom
2 Bedroom
3 Bedroom
4 Bedroom
5 Bedroom (Section 8 only)
6 + Bedroom (Section 8 only)

Deconcentration Policy

Deconcentration of Poverty and Income-Mixing [24 CFR 903.1 and 903.2] HACC's admission policy must be designed to provide for deconcentration of poverty and income-mixing by bringing higher income tenants into lower income projects and lower income tenants into higher income projects. A statement of HACC's deconcentration policies must be in included in its annual plan [24 CFR 903.7(b)]. HACC's deconcentration policy must comply with its obligation to meet the income targeting requirement [24 CFR 903.2(c) (5)]. Developments subject to the deconcentration requirement are referred to as 'covered developments' and include general occupancy (family) public housing developments. The following developments are not subject to deconcentration and income mixing requirements: developments operated by HACC with fewer than 100 public housing units; mixed population or developments designated specifically for elderly or disabled families; developments operated by HACC with only one general occupancy development; developments approved for demolition or for conversion to tenant-based public housing; and developments approved for a mixed-finance plan using HOPE VI or public housing funds [24 CFR 903.2(b)].

Steps for Implementation [24 CFR 903.2(c) (1)]. To implement the statutory requirement to deconcentrate poverty and provide for income mixing in covered developments, HACC must comply with the following steps: Step 1. HACC must determine the average income of all families residing in all HACC's covered developments. HACC may use the median income, instead of average income, provided that HACC includes a written explanation in its annual plan justifying the use of median income. **HACC Policy - HACC will determine the average income of all families in all covered developments on an annual basis. Step 2. HACC must determine the average income (or median income, if median income was used in Step 1) of all families residing in each covered development. In determining average income for each development, HACC has the option of adjusting its income analysis for unit size in accordance with procedures prescribed by HUD. HACC Policy - HACC will determine the average income of all families residing in each covered development (not adjusting for unit size) on an annual basis. Step 3. HACC must then determine whether each of its covered developments falls above, within, or below the established income range (EIR), which is from 85% to 115% of the average family income determined in Step 1. However, the upper limit must never be less than the income at which a family would be defined as an extremely low income family (30% of median income).**

Attachment E

2019 Capital Fund Completed Projects

- Project # 19004 – OCVM/SS Roof Project - $163,322.78
- Project # 19005 – Clackamas Hts. Decks - $126,688.72
- Project # 19006 – Scattered Sites Furnace Project - $86,500.00
- Project # 19009 – Asbestos Abatement Services - $50,000.00
- Project # 19010 – Asbestos Air Monitoring Services - $30,000.00
- Project # 19011 – Modernization of 9680 74th - $132,503.21
- Project # 19012 – HACC Wide Flooring - $250,000.00

2020 Proposed Capital Fund Projects

- On Demand Moving Contract - $25,000.00
- On Demand Cabinet Contract - $125,000.00
- Scattered Sites Fencing Project - $175,000.00
- On Demand Flatwork Project - $135,000.00
- Hillside Manor Elevator Upgrades - $700,000.00

Attachment F
Housing Authority of Clackamas County
2020 Capital Fund Budget Summary

Acct #	**2018 Capital Fund Budget**	Total Budgeted Costs								
1406	HA-Wide Operations (20% Max)	306,398.50								
1408	HA-Wide Management Improvement	500.00								
	Administration (10% Max w/o in house A&E)									
1410	Central Office, Capital Fund adm	122,559.40								
1410	CFP Capital Improvement Coordinator A&E design work									
1411	Audit	6,500.00								
	PHA Wide Fees and Costs									
1430	Architectural, engineering, consulting; mold asbestos testing & remediation, other related expenses	25,000.00								
	PHA Wide Site Improvements									
1450	Paving, fencing, landscape, garden, utilities, 504 accomodation	15,000.00								
	PHA Wide Dwelling Improvement									
1460	Cabinets, doors, plumbing, HVAC, siding windows, roofs, kitchens, porches, patios, 504 accomodations	744,779.10								
	PHA Wide Dwelling Equipment									
1465	Ranges and refrigerators	0.00								
	PHA Wide Non-Dwelling Equipment									
1475	Tools, equipment, furnishings, vehicles, Office equipment	1,000.00								
1495	Relocation Costs	10,000.00								
	Asset Managed Properties - specific projects									
1450	Site Work (concrete, drive, walks, landscape, drainage	0.00								
1460	Dwelling Renovation (Bath, Kitchen, Cabinets, Floooring etc.)	0.00								
1460	Energy Improvements per Energ	0.00								
1470	Non-Dwelling Renovation (flooring, HVAC, windows, siding, cabinets, paint, etc.)	0.00								
	Grand Total Capital Fund Budget	1,231,737.00								

ATTACHMENT G

Development #1 Hillside Manor			
Name of Public Housing Project: **Hillside Manor**	PIC Development ID: **OR001005000**	Conversion Type (i.e. PBV or PBRA): **PBV**	Transfer of Assistance: **No**
Total Units **100**	Pre-Rad Unit Type: **Family**	Post RAD Unit Type if different: **N/A**	Total Annual Capital Fund allocation **Per unit is $1,640** **Total is $164,000**
Bedroom Type **Studio/Efficiency: 0** **One Bedroom: 96** **Two Bedroom: 4**	Number of Units Pre Conversion **100**	Number of Units Post Conversion **100**	Change in number of units per bedroom type and why **N/A**
Development #2 Hillside Park			
Name of Public Housing Project: **Hillside Park**	PIC Development ID: **OR001003000**	Conversion Type (i.e. PBV or PBRA): **PBV**	Transfer of Assistance: **No**
Total Units **100**	Pre-Rad Unit Type: **Family**	Post RAD Unit Type if different: **N/A**	Total Annual Capital Fund allocation divided by total number of Public Housing units in PHA, multiplied by total number of units in project **Per unit is $1,640** **Total is $164,000**
Bedroom Type **Studio/Efficiency: 0** **One Bedroom: 25** **Two Bedroom: 75**	Number of Units Pre Conversion **100**	Number of Units Post Conversion **100**	Change in number of units per bedroom type and why **N/A**

Development #3 Oregon City View Manor			
Name of Public Housing Project: **Oregon City View Manor**	PIC Development ID: **OR001004000**	Conversion Type (i.e. PBV or PBRA): **PBV**	Transfer of Assistance: **No**
Total Units **100**	Pre-Rad Unit Type: **Family**	Post RAD Unit Type if different: **N/A**	Total Annual Capital Fund allocation divided by total number of Public Housing units in PHA, multiplied by total number of units in project **Per unit is $1,640** **Total is $164,000**
Bedroom Type **Studio/Efficiency: 0** **One Bedroom: 36** **Two Bedroom: 30** **Three Bedroom: 24** **Four Bedroom: 10**	Number of Units Pre Conversion **100**	Number of Units Post Conversion **100**	Change in number of units per bedroom type and why **N/A**
Development #4 Clackamas Heights			
Name of Public Housing Project: **Clackamas Heights**	PIC Development ID: **OR001001000**	Conversion Type (i.e. PBV or PBRA): **PBV**	Transfer of Assistance: **No**
Total Units **100**	Pre-Rad Unit Type: **Family**	Post RAD Unit Type if different: **N/A**	Total Annual Capital Fund allocation divided by total number of Public Housing units in PHA, multiplied by total number of units in project **Per unit is $1,640** **Total is $164,000**
Bedroom Type **Studio/Efficiency: 28** **One Bedroom: 50** **Two Bedroom: 22** **Three Bedroom: 22**	Number of Units Pre Conversion **100**	Number of Units Post Conversion **100**	Change in number of units per bedroom type and why **N/A**

ATTACHMENT G

Development #5 Scattered Sites			
Name of Public Housing Project: **Scattered Sites**	PIC Development ID: **OR001002000**	Conversion Type (i.e. PBV or PBRA): **PBV**	Transfer of Assistance: **No**
Total Units **145**	Pre-Rad Unit Type: **Family**	Post RAD Unit Type if different: **N/A**	Total Annual Capital Fund allocation divided by total number of Public Housing units in PHA, multiplied by total number of units in project **Per unit is $1,640** **Total is $237,800**
Bedroom Type Studio/Efficiency: 0 One Bedroom: 0 Two Bedroom: 2 Three Bedroom: 126 Four Bedroom: 17	Number of Units Pre Conversion **145**	Number of Units Post Conversion **100**	Change in number of units per bedroom type and why **N/A**

Violence Against Women (VAWA) Statement

Housing Authority of Clackamas County (HACC) addresses VAWA in the Section 8 Housing Choice Voucher Administrative Plan and the Public Housing Admissions and Continued Occupancy Policy. The responsibility of not terminating families from housing for reasons that fall under the VAWA regulation is particularly addressed. HACC has an Emergency Transfer Plan for victims of domestic violence in our housing programs.

We offer a local preference in the Housing Choice Voucher program for victims of Domestic Violence working with case management. We partner with several community partners like Northwest Family Services, Clackamas Women's Services, A Safe Place and Northwest Housing Alternatives to administer the Domestic Violence preference vouchers.

In addition, we are in continuous contact with County and City agencies, including the various law enforcement agencies, for current tenant's experiencing Domestic Violence.

HACC also partners with Clackamas County Social Services and Behavioral Health as well as the State Department of Human Services to use funds in a transitional housing program and Shelter + Care program under the Continuum of Care, where many victims of Domestic Violence are housed and provided services.

In summary, we follow the VAWA program policies and regulations with the goal of providing safeguards for the families falling under the VAWA related program requirements and refer households, as needed, to local domestic violence service provider partners. HACC has amended all its policies to comply with VAWA.

_____ _____

Jill Smith, Executive Director Date

Following the earlier of the end of the construction period identified in the HUD-approved Financing Plan or actual construction, the PHA will no longer be eligible to receive RAD Rehab Assistance Payments, and all units under contract will be eligible for payment only for occupied units or for vacancy payments, as applicable. MTW agencies may not alter this requirement.

9. **HQS Inspections.** Under current regulations at 24 CFR § 983.103(b) a unit covered under a HAP Contract must be inspected and must meet HQS before assistance can be paid on behalf of a household. In addition, section 8(o)(8)(A) of the Act provides that HAP Contract units must be inspected to ensure compliance with HQS prior to payment of any assistance on behalf of a family. When Work is occuring under RAD, HUD requires that all units meet HQS no later than the date of completion of the Work as indicated in the RCC. Consequently, HUD is waiving and establishing an alternative requirement to 24 CFR § 983.103(b) and section 8(o)(8)(A) of the Act in such cases.

10. **Floating Units.** For mixed-income Converting Projects where PHAs are currently exercising their discretion to allow subsidized units to float within a project redeveloped with funding under a Choice Neighborhoods Implementation or HOPE VI grant, or as part of a Mixed-Finance project, upon the request of the Voucher Agency that will administer the Covered Project, HUD will permit PBV assistance to float among units within the project having the same bedroom size. A unit to which assistance is floated must be comparable in condition to the unit it is replacing (i.e., the unit must be of the same quality and amenities as the unit it is replacing). Assistance may float from a Section 504 accessible unit only to another Section 504 accessible unit that has the same bedroom size and accessibility features. Units that float are not specifically designated under the HAP Contract. Therefore, the requirements in 24 CFR § 983.203(c) that the HAP Contract provide "the location of each contract unit" and "the area of each contract unit" are waived. Instead, the HAP Contract must specify the number and type of units in the property that are designated as RAD units, including any excepted units. From the time of the initial execution of the PBV RAD HAP Contract, the property must maintain the same number and type of RAD units, including the same number and type of Section 504 accessible units. Floating units are subject to all of the requirements in this Notice and the PBV regulations, including physical inspections, rent adjustments, and income-mixing requirements. The alternative requirements with respect to floating units do not apply to non-RAD PBV units.

C. PBV Resident Rights and Participation.

1. **No Rescreening of Tenants upon Conversion.** Pursuant to the RAD Statute, at conversion, current households cannot be excluded from occupancy at the Covered Project based on any rescreening, income eligibility, or income targeting. With respect to occupancy in the Covered Project, current households in the Converting Project will be grandfathered for application of any eligibility criteria to conditions that occurred prior to conversion but will be subject to any ongoing eligibility requirements for actions that occur after conversion.[32] Post-conversion, the tenure of all residents of the Covered Project is protected pursuant to PBV requirements regarding continued occupancy unless explicitly modified in this Notice (e.g., rent phase-in provisions). For example, a unit with a household that was over-income at time of conversion would continue to be treated as an assisted unit. Thus, 24 CFR § 982.201, concerning eligibility and targeting of tenants for initial occupancy, will not apply for current households. Once the grandfathered household moves out, the unit must be leased to an eligible family. MTW agencies may not alter this requirement. Further, so as to facilitate the right to return to the assisted property, this provision shall apply to current public housing residents of the Converting Project that will reside in non-RAD PBV units or non-RAD PBRA units placed in a project that contain RAD PBV units or RAD PBRA units. Such families and such contract units will otherwise be subject to all requirements of the applicable program, specifically 24 CFR § 983 for non-RAD PBV units and the PBRA requirements governing the applicable contract for non-RAD PBRA units.[33]

2. **Right to Return.** See section 1.4.A.5(ii) and the RAD Fair Housing, Civil Rights, and Relocation Notice regarding a resident's right to return.

3. **Renewal of Lease.** Since publication of the PIH Notice 2012-32 Rev 1, the regulations under 24 CFR part 983 have been amended requiring Project Owners to renew all leases upon lease expiration, unless cause exists. MTW agencies may not alter this requirement.

4. **Phase-in of Tenant Rent Increases.** If a tenant's monthly rent increases by more than the greater of 10 percent or $25 purely as a result of conversion, the rent increase will be phased in over 3 or 5 years. To implement this provision, HUD is specifying

[32] These protections (as well as all protections in this Notice for current households) also apply when a household is relocated to facilitate new construction or repairs following conversion and subsequently returns to the Covered Project.

[33] For non-RAD PBV households, applicable program requirements includes the requirement that any admission to the project must be initially eligible for a HAP payment at admission to the program, which means their TTP may not exceed the gross rent for the unit at that time.

alternative requirements for section 3(a)(1) of the Act, as well as 24 CFR § 983.3 (definition of "total tenant payment" (TTP)) to the extent necessary to allow for the phase-in of tenant rent increases. A PHA must create a policy setting the length of the phase-in period at three years, five years or a combination depending on circumstances. For example, a PHA may create a policy that uses a three year phase-in for smaller increases in rent and a five year phase-in for larger increases in rent. This policy must be in place at conversion and may not be modified after conversion.

The method described below explains the set percentage-based phase-in a Project Owner must follow according to the phase-in period established. For purposes of this section "Calculated PBV TTP" refers to the TTP calculated in accordance with regulations at 24 CFR §5.628 and the "most recently paid TTP" refers to the TTP recorded on line 9j of the family's most recent HUD Form 50058. If a family in a project converting from Public Housing to PBV was paying a flat rent immediately prior to conversion, the PHA should use the flat rent amount to calculate the phase-in amount for Year 1, as illustrated below.

Three Year Phase-in:

- Year 1: Any recertification (interim or annual) performed prior to the second annual recertification after conversion – 33% of difference between most recently paid TTP or flat rent and the Calculated PBV TTP
- Year 2: Year 2 Annual Recertification (AR) and any Interim Recertification (IR) prior to Year 3 AR – 50% of difference between most recently paid TTP and the Calculated PBV TTP
- Year 3: Year 3 AR and all subsequent recertifications – Full Calculated PBV TTP [34]

Five Year Phase in:

- Year 1: Any recertification (interim or annual) performed prior to the second annual recertification after conversion – 20% of difference between most recently paid TTP or flat rent and the Calculated PBV TTP
- Year 2: Year 2 AR and any IR prior to Year 3 AR – 25% of difference between most recently paid TTP and the Calculated PBV TTP

[34] For example, where a resident's most recently paid TTP is $100, but the Calculated PBV TTP is $200 and remains $200 for the period of the resident's occupancy, (i.e. no changes in income) the resident would continue to pay the same rent and utilities for which it was responsible prior to conversion. At the first recertification following conversion, the resident's contribution would increase by 33% of $100 to $133. At the second AR, the resdient's contribution would increase by 50% of the $66 differential to the standard TPP, increasing to $166. At the third AR, the resident's contribution would increase to $200 and the resident would continue to pay the Calculated PBV TTP for the duration of their tenancy.

- Year 3: Year 3 AR and any IR prior to Year 4 AR – 33% of difference between most recently paid TTP and the Calculated PBV TTP
- Year 4: Year 4 AR and any IR prior to Year 5 AR – 50% of difference between most recently paid TTP and the Calculated PBV TTP
- Year 5 AR and all subsequent recertifications – Full Calculated PBV TTP

Please Note: In either the three year phase-in or the five-year phase-in, once the Calculated PBV TTP is equal to or less than the previous TTP, the phase-in ends and tenants will pay full TTP from that point forward. MTW agencies must also implement a three or five-year phase-in for impacted residents, but may alter the terms above as long as it establishes a written policy setting forth the alternative terms.

5. **Family Self Sufficiency (FSS) and Resident Opportunities and Self Sufficiency Service Coordinator (ROSS-SC) programs.** Public Housing residents that are currently FSS participants will continue to be eligible for FSS once their housing is converted under RAD. The PHA may continue to use any FSS funds already awarded to serve those FSS participants who live in units converted by RAD. At the completion of the FSS grant, PHAs should follow the normal closeout procedures outlined in the grant agreement. If the PHA continues to run an FSS program that serves PH and/or HCV participants, the PHA will continue to be eligible (subject to NOFA requirements) to apply for FSS funding and may use that funding to serve PH, HCV and/or PBRA participants in its FSS program. Due to the program merger between PH FSS and HCV FSS that took place pursuant to the FY14 Appropriations Act (and was continued in the subsequent Appropriation Acts), no special provisions are required to continue serving FSS participants that live in public housing units converting to PBV under RAD.

   However, PHAs should note that there are certain FSS requirements (e.g., escrow calculation and escrow forfeitures) that apply differently depending on whether the FSS participant is a participant under the HCV program or a public housing resident, and PHAs must follow such requirements accordingly. All PHAs will be required to administer the FSS program in accordance with FSS regulations at 24 CFR part 984, the participants' contracts of participation, and the alternative requirements established in the "Waivers and Alternative Requirements for the FSS Program" Federal Register notice, published on December 29, 2014, at 79 FR 78100.[35] Further,

[35] The funding streams for the PH FSS Program and the HCV FSS Program were first merged pursuant to the FY 2014 appropriations act. As a result, PHAs can serve both PH residents and HCV participants, including PBV participants, with FSS funding awarded under the FY 2014 FSS Notice of Funding Availability (FSS NOFA) and

upon conversion to PBV, already escrowed funds for FSS participants shall be transferred into the HCV escrow account and be considered TBRA funds, thus reverting to the HAP account if forfeited by the FSS participant.

For information on FSS PIC reporting requirements for RAD conversions, see Notice PIH 2016-08 at http://portal.hud.gov/hudportal/documents/huddoc?id=pih2016-08.pdf.

Current ROSS-SC grantees will be able to finish out their current ROSS-SC grants once their housing is converted under RAD. However, once the property is converted, it will no longer be eligible to be counted towards the unit count for future ROSS-SC grants, nor will its residents be eligible to be served by future ROSS-SC grants, which, by statute, can only serve public housing residents. At the completion of the ROSS-SC grant, PHAs should follow the normal closeout procedures outlined in the grant agreement. Please note that ROSS-SC grantees may be a non-profit or local Resident Association and this consequence of a RAD conversion may impact those entities.

6. **Resident Participation and Funding.** In accordance with Attachment 1B, residents of Covered Projects with assistance converted to PBV will have the right to establish and operate a resident organization for the purpose of addressing issues related to their living environment and be eligible for resident participation funding.

7. **Resident Procedural Rights.** The following items must be incorporated into both the Section 8 Administrative Plan and the Project Owner's lease, which includes the required tenancy addendum, as appropriate. Evidence of such incorporation may be requested by HUD for purposes of monitoring the program.

    i. **Termination Notification**. HUD is incorporating additional termination notification requirements to comply with section 6 of the Act for public housing projects that convert assistance under RAD. In addition to the regulations at 24 CFR § 983.257 related to Project Owner termination of tenancy and eviction (which MTW agencies may not alter) the termination procedure for RAD conversions to PBV will require that PHAs provide adequate written notice of termination of the lease which shall be :
        a. A reasonable period of time, but not to exceed 30 days:

any other NOFA under which the combination of funds remains in the applicable appropriations act. For PHAs that had managed both programs separately and now have a merged program, a conversion to PBV should not impact their FSS participants.

ii. If the health or safety of other tenants, Project Owner employees, or persons residing in the immediate vicinity of the premises is threatened; or

iii. In the event of any drug-related or violent criminal activity or any felony conviction;

b. Not less than 14 days in the case of nonpayment of rent; and

c. Not less than 30 days in any other case, except that if a State or local law provides for a shorter period of time, such shorter period shall apply.

ii. **Grievance Process.** Pursuant to requirements in the RAD Statute, HUD is establishing additional resident procedural rights to comply with section 6 of the Act.

For issues related to tenancy and termination of assistance, PBV program rules require the Project Owner to provide an opportunity for an informal hearing, as outlined in 24 CFR § 982.555. RAD will specify alternative requirements for 24 CFR § 982.555(b) in part, which outlines when informal hearings are not required, to require that:

a. In addition to reasons that require an opportunity for an informal hearing given in 24 CFR § 982.555(a)(1)(i)-(vi),[36] an opportunity for an informal hearing must be given to residents for any dispute that a resident may have with respect to a Project Owner action in accordance with the individual's lease or the contract administrator in accordance with RAD PBV requirements that adversely affect the resident's rights, obligations, welfare, or status.

i. For any hearing required under 24 CFR § 982.555(a)(1)(i)-(vi), the contract administrator will perform the hearing, as is the current standard in the program. The hearing officer must be selected in accordance with 24 CFR § 982.555(e)(4)(i).

ii. For any additional hearings required under RAD, the Project Owner will perform the hearing.

b. There is no right to an informal hearing for class grievances or to disputes between residents not involving the Project Owner or contract administrator.

c. The Project Owner gives residents notice of their ability to request an informal hearing as outlined in 24 CFR § 982.555(c)(1) for informal hearings that will address circumstances that fall outside of the scope of 24 CFR § 982.555(a)(1)(i)-(vi).

[36] § 982.555(a)(1)(iv) is not relevant to RAD as the tenant-based certificate program has been repealed.

d. The Project Owner provides opportunity for an informal hearing before an eviction.

Current PBV program rules require that hearing procedures must be outlined in the PHA's Section 8 Administrative Plan.

8. **Earned Income Disregard (EID).** Tenants who are employed and are currently receiving the EID exclusion at the time of conversion will continue to receive the EID after conversion, in accordance with regulations at 24 CFR § 5.617. Upon the expiration of the EID for such families, the rent adjustment shall not be subject to rent phase-in, as described in Section 1.6.C.4; instead, the rent will automatically rise to the appropriate rent level based upon tenant income at that time.

   Under the Housing Choice Voucher program, the EID exclusion is limited only to persons with disabilities (24 CFR § 5.617(b)). In order to allow all tenants (including non-disabled persons) who are employed and currently receiving the EID at the time of conversion to continue to benefit from this exclusion in the PBV project, the provision in 24 CFR § 5.617(b) limiting EID to disabled persons is waived. The waiver, and resulting alternative requirement, apply only to tenants receiving the EID at the time of conversion. No other tenant (e.g., tenants that move into the property following conversion or tenants who at one time received the EID but are not receiving the EID exclusion at the time of conversion due to loss of employment) is covered by this waiver.

9. **Jobs Plus.** Jobs Plus grantees awarded FY14 and future funds that convert the Jobs Plus target projects(s) under RAD will be able to finish out their Jobs Plus period of performance at that site unless significant relocation and/or change in building occupancy is planned. If either is planned at the Jobs Plus target project(s), HUD may allow for a modification of the Jobs Plus work plan or may, at the Secretary's discretion, choose to end the Jobs Plus program at that project.

10. **When Total Tenant Payment Exceeds Gross Rent.** Under normal PBV rules, the PHA may select an occupied unit to be included under the PBV HAP Contract only if the unit's occupants are eligible for housing assistance payments (24 CFR § 983.53(c)). Also, a PHA must remove a unit from the contract when no assistance has been paid for 180 days because the family's TTP has risen to a level that is equal to or greater than the contract rent, plus any utility allowance, for the unit (i.e., the Gross Rent)) (24 CFR § 983.258). Since the rent limitation under this Section of the Notice may result in a family's TTP equaling or exceeding the gross rent for the unit, for residents living in the Converting Project prior to conversion and who will return

to the Covered Project after conversion, HUD is waiving both of these provisions and requiring that the unit for such families be placed on and/or remain under the HAP Contract when TTP equals or exceeds the Gross Rent. Further, HUD is establishing the alternative requirement that until such time that the family's TTP falls below the gross rent, the rent to the owner for the unit will equal the lesser of (a) the family's TTP, less the Utility Allowance, or (b) any applicable maximum rent under LIHTC regulations. When the family's TTP falls below the gross rent, normal PBV rules shall apply. As necessary to implement this alternative provision, HUD is waiving the provisions of Section 8(o)(13)(H) of the Act and the implementing regulations at 24 CFR § 983.301 as modified by Section 1.6.B.5 of this Notice.[37] In such cases, the resident is considered a participant under the program and all of the family obligations and protections under RAD and PBV apply to the resident. Likewise, all requirements with respect to the unit, such as compliance with the HQS requirements, apply as long as the unit is under HAP Contract. The PHA is required to process these individuals through the Form 50058 submodule in PIC.

Following conversion, 24 CFR § 983.53(d) applies, and any new families referred to the RAD PBV project must be initially eligible for a HAP payment at admission to the program, which means their TTP may not exceed the gross rent for the unit at that time. Further, a PHA must remove a unit from the contract when no assistance has been paid for 180 days. If units are removed from the HAP contract because a new admission's TTP comes to equal or exceed the gross rent for the unit and if the project is fully assisted, HUD is imposing an alternative requirement that the PHA must reinstate the unit after the family has vacated the property. If the project is partially assisted, the PHA may substitute a different unit for the unit on the HAP contract in accordance with 24 CFR §983.207 or, where "floating" units have been permitted, Section 1.6.B.10 of this Notice.

11. **Under-Occupied Unit.** If a family is in an under-occupied unit under 24 CFR § 983.260 at the time of conversion, the family may remain in this unit until an appropriate-sized unit becomes available in the Covered Project. When an appropriate sized unit becomes available in the Covered Project, the family living in the under-occupied unit must move to the appropriate-sized unit within a reasonable period of time, as determined by the administering Voucher Agency. In order to allow the family to remain in the under-occupied unit until an appropriate-sized unit becomes

[37] For example, a public housing family residing in a property converting under RAD has a TTP of $600. The property has an initial Contract Rent of $500, with a $50 Utility Allowance. Following conversion, the residents is still responsible for paying $600 in tenant rent and utilities.

available in the Covered Project, 24 CFR § 983.260 is waived. MTW agencies may not modify this requirement.

D. PBV: Other Miscellaneous Provisions

1. **Access to Records, Including Requests for Information Related to Evaluation of Demonstration.** PHAs and the Project Owner must cooperate with any reasonable HUD request for data to support program evaluation, including but not limited to project financial statements, operating data, Choice-Mobility utilization, and rehabilitation work. Please see Appendix IV for reporting units in Form HUD-50058.

2. **Additional Monitoring Requirement.** The Owner must submit to the administering PHA and the PHA's Board must approve the operating budget for the Covered Project annually in accordance with HUD requirements.[38]

3. **Davis-Bacon Act and Section 3 of the Housing and Urban Development Act of 1968 (Section 3).** This section has been moved to 1.4.A.13 and 1.4.A.14.

4. **Establishment of Waiting List.** 24 CFR § 983.251 sets out PBV program requirements related to establishing and maintaining a voucher-wide, PBV program-wide, or site-based waiting list from which residents for the Covered Project will be admitted. These provisions will apply unless the project is covered by a remedial order or agreement that specifies the type of waiting list and other waiting list policies. The PHA shall consider the best means to transition applicants from the current public housing waiting list, including:

   i. Transferring an existing site-based waiting list to a new site-based waiting list.
   ii. Transferring an existing site-based waiting list to a PBV program-wide or HCV program-wide waiting list.
   iii. Transferring an existing community-wide public housing waiting list to a PBV program-wide or HCV program-wide waiting list, an option particularly relevant for PHAs converting their entire portfolio under RAD.
   iv. Informing applicants on a community-wide public housing waiting list how to transfer their application to one or more newly created site-based waiting lists.

   For any applicants on the public housing waiting list that are likely to be ineligible for admission to a Covered Project converting to PBV because the household's TTP is

[38] For PBV conversions that are not FHA-insured, a future HUD notice will describe project financial data that may be required to be submitted by a PBV owner for purposes of monitoring and evaluation, given that PBV projects do not submit annual financial statements to HUD/REAC.

likely to exceed the RAD gross rent, the PHA shall consider transferring such household, consistent with program requirements for administration of waiting lists, to the PHA's remaining public housing waiting list(s) or to another voucher waiting list, in addition to transferring such household to the waiting list for the Covered Project.

To the extent any wait list relies on the date and time of application, the applicants shall have priority on the wait list(s) to which their application was transferred in accordance with the date and time of their application to the original waiting list.

If the PHA is transferring assistance to another neighborhood and, as a result of the transfer of the waiting list, the applicant would only be eligible for a unit in a location which is materially different from the location to which the applicant applied, the PHA must notify applicants on the wait-list of the transfer of assistance, and on how they can apply for residency at other sites.

If using a site-based waiting list, PHAs shall establish a waiting list in accordance with 24 CFR § 903.7(b)(2)(ii)-(iv) to ensure that applicants on the PHA's public housing community-wide waiting list have been offered placement on the Covered Project's initial waiting list. In all cases, PHAs have the discretion to determine the most appropriate means of informing applicants on the public housing community-wide waiting list given the number of applicants, PHA resources, and admissions requirements of the projects being converted under RAD. A PHA may consider contacting every applicant on the public housing waiting list via direct mailing; advertising the availability of housing to the population that is less likely to apply, both minority and non-minority groups, through various forms of media (e.g., radio stations, posters, newspapers) within the marketing area; informing local non-profit entities and advocacy groups (e.g., disability rights groups); and conducting other outreach as appropriate. Any activities to contact applicants on the public housing waiting list must be conducted in accordance with the requirements for effective communication with persons with disabilities at 24 CFR § 8.6 and with the obligation to provide meaningful access for persons with limited English proficiency (LEP).[39]

A PHA must maintain any site-based waiting list in accordance with all applicable civil rights and fair housing laws and regulations.

[39] For more information on serving persons with LEP, please see HUD's Final guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (72 FR 2732), published on January 22, 2007.

To implement this provision, HUD is specifying alternative requirements for 24 CFR § 983.251(c)(2). However, after the initial waiting list has been established, the PHA shall administer its waiting list for the Covered Project in accordance with 24 CFR § 983.251(c).

5. **Mandatory Insurance Coverage.** The Covered Project shall maintain at all times commercially available property and liability insurance to protect the project from financial loss and, to the extent insurance proceeds permit, promptly restore, reconstruct, and/or repair any damaged or destroyed project property.

6. **Agreement Waiver.** This section has been moved to 1.6.B.8.

7. **Future Refinancing.** Project Owners must receive HUD approval for any refinancing or restructuring of secured debt during the HAP Contract term to ensure the financing is consistent with long-term preservation of the Covered Project. With respect to any financing contemplated at the time of conversion (including any permanent financing which is a conversion or take-out of construction financing), such consent may be evidenced through the RCC.

8. **Administrative Fees for Public Housing Conversions During the Year of Conversion**. For the remainder of the Calendar Year in which the HAP Contract becomes effective (i.e., the "year of conversion"), RAD PBV projects will be funded with public housing funds. For example, if the project's assistance converts effective July 1, 2015, the public housing ACC between the PHA and HUD will be amended to reflect the number of units under HAP Contract, but will be for zero dollars, and the RAD PBV HAP Contract will be funded with public housing money for July through December 2015. Since TBRA is not the source of funds, PHAs should not report leasing and expenses into VMS during this period, and PHAs will not receive section 8 administrative fee funding for converted units during this time.

   PHAs operating HCV program typically receive administrative fees for units under a HAP Contract, consistent with recent appropriation act references to "section 8(q) of the [United States Housing Act of 1937] and related appropriations act provisions in effect immediately before the Quality Housing and Work Responsibility Act of 1998" and 24 CFR § 982.152(b). During the year of conversion mentioned in the preceding paragraph, these provisions are waived. PHAs will not receive Section 8 administrative fees for PBV RAD units during the year of conversion.

After the year of conversion, the Section 8 ACC will be amended to include Section 8 funding that corresponds to the units covered by the Section 8 ACC. At that time, the regular Section 8 administrative fee funding provisions will apply.

9. **Choice-Mobility.** One of the key features of the PBV program is the mobility component, which provides that if the family has elected to terminate the assisted lease at any time after the first year of occupancy in accordance with program requirements, the PHA must offer the family the opportunity for continued tenant-based rental assistance, in the form of either assistance under the voucher program or other comparable tenant-based rental assistance.

   If as a result of participation in RAD a significant percentage of the PHA's HCV program becomes PBV assistance, it is possible for most or all of a PHA's turnover vouchers to be used to assist those RAD PBV families who wish to exercise mobility. While HUD is committed to ensuring mobility remains a cornerstone of RAD policy, HUD recognizes that it remains important for the PHA to still be able to use tenant-based vouchers to address the specific housing needs and priorities of the community. Therefore, HUD is establishing an alternative requirement for PHAs where, as a result of RAD, the total number of PBV units (including RAD PBV units) under HAP Contract administered by the PHA exceeds 20 percent of the PHA's authorized units under its HCV ACC with HUD.

   The alternative mobility policy provides that an eligible voucher agency would not be required to provide more than three-quarters of its turnover vouchers in any single year to the residents of Covered Projects. While a voucher agency is not required to establish a voucher inventory turnover cap, if such a cap is implemented, the voucher agency must create and maintain a waiting list in the order in which the requests from eligible households were received. In order to adopt this provision, this alternative mobility policy must be included in an eligible PHA's administrative plan.

   To effectuate this provision, HUD is providing an alternative requirement to Section 8(o)(13)(E) of the Act and 24 CFR § 983.261(c). Please note that this alternative requirement does not apply to PBVs entered into outside of the context of RAD. MTW agencies may not alter this requirement.

10. **Reserve for Replacement**. The Project Owner shall establish and maintain a replacement reserve in an interest-bearing account to aid in funding extraordinary maintenance and repair and replacement of capital items in accordance with applicable regulations. The reserve must be built up to and maintained at a level determined by HUD to be sufficient to meet projected requirements. For FHA

transactions, Replacement Reserves shall be maintained in accordance with the FHA Regulatory Agreement. For all other transactions, Replacement Reserves shall be maintained in a bank account or similar instrument, as approved by HUD, where funds will be held by the Project Owner or mortgagee and may be drawn from the reserve account and used subject to HUD guidelines.

1.7 Special Provisions Affecting Conversions to PBRA

Under the Demonstration, HUD has the authority to waive statutory and regulatory provisions governing the PBRA program, or to establish alternative requirements for the effective conversion of assistance. Additionally, the RAD Statute imposes certain unique requirements and authorizes HUD to establish requirements for converted assistance under the demonstration.

For public housing projects converting assistance to PBRA under the First Component of the Demonstration, 24 CFR part 880, Section 8 Housing Assistance Payments Program for New Construction and applicable standing and subsequent Office of Housing guidance[40] will apply, except for the provisions listed below. These "special" provisions are grouped into three categories: Contract Terms, Resident Rights and Participation, and Other Miscellaneous Provisions. Where applicable, reference is made to the affected statute and/or regulation. For additional background purposes, HUD has provided Appendix I, which is a copy of the existing 24 CFR part 880 regulation with the provisions stricken that will not apply to Covered Projects. Additionally, Appendix II includes the specific provisions of the Act that are inapplicable to PBRA conversions. Finally, Appendix III includes the site and neighborhood standards that apply to PBRA.

A. PBRA Contract Terms.

1. **Length of Contract.** Covered Projects shall have an initial HAP term of 20 years. To implement this provision, HUD is specifying alternative requirements for section 8(d)(2)(A) of the Act, which establishes a maximum term of 15 years for "an existing structure." Additionally, 24 CFR § 880.502, which imposes maximum contract terms for New Construction projects consistent with statutory authority that was repealed in 1983, does not apply.

2. **Mandatory Contract Renewal.** Section 524 of MAHRAA and 24 CFR part 402 currently govern renewals of expiring or terminating project-based section 8 HAP Contracts and, in general, require HUD to renew such contracts "at the request of the

[40] Examples of Office of Housing guidance include handbooks such as "Occupancy Requirements of Subsidized Multifamily Housing Programs" (4350.3) and "Multifamily Asset Management and Project Servicing" (4350.1). Future changes to part 880 would apply to RAD as long as the future changes are not provisions that have been stricken in the final Notice.

Special Attention of:
Public Housing Agencies
Public Housing Hub Office Directors
Public Housing Program Center Directors
Regional Directors
Field Office Directors
RAD Transaction Managers

Notice H 2014-09
PIH 2014-17

Issued: July 14, 2014

This notice remains in effect until amended, superseded, or rescinded.

Cross Reference: PIH Notice 2012-32 (HA) REV 1

Subject: **Relocation Requirements under the Rental Assistance Demonstration (RAD) Program, Public Housing in the First Component**

1. Purpose

This Notice provides public housing agencies (PHAs)[1] and their partners with information and resources on applicable program and relocation assistance requirements when planning for or implementing resident moves as a result of a **Rental Assistance Demonstration (RAD)** conversion[2] under the first component of the demonstration.[3] This Notice provides guidance on RAD relocation requirements and requirements of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended, (URA), as they relate to the public housing conversion process under the first component.[4]

[1] This Notice always uses the term "PHA" to refer to the owner of the project prior to and after the RAD conversion, even though, in some cases, the owner of the converted RAD project may be another public entity, a non-profit organization, or other owner (e.g., low-income housing tax credit owner). In addition, this Notice uses "PHA" to refer to the "displacing agency," a URA term that means the agency or person that carries out a program or project, which will cause a resident to become a displaced person. Projects vary and, for any specific task described in this Notice, may require substituting in a reference to a party that is more appropriate for a specific project.

[2] The content of this Notice should not be relied upon in carrying out any other activities funded under any other HUD program, except where specifically directed by HUD.

[3] The "first component" of RAD allows public housing and Moderate Rehabilitation properties to convert assistance; the "second component" refers to conversion of Rent Supplement, Rental Assistance Payment, and Moderate Rehabilitation properties upon contract expiration or termination.

[4] Relocation concerns and URA requirements apply to both components of RAD. This notice provides guidance only as to the first component.

Relocation assistance provided pursuant to public housing and RAD requirements is broader than URA relocation assistance requirements. Not all specific situations requiring relocation under RAD may trigger URA assistance requirements. In addition, whereas all qualifying residents[5] of a converting public housing project are eligible for relocation assistance under RAD, some residents or household members may not meet the statutory and regulatory requirements for eligibility under URA. This Notice supersedes PIH Notice 2012-32 (HA), REV-1, with respect to relocation matters. This Notice also specifically addresses when relocation may begin (see Section 9 below). As necessary, the Department will issue additional guidance on relocation issues and requirements as they relate to RAD.

2. Background

RAD allows public housing properties to convert assistance to long-term project-based Section 8 contracts. In many cases, a RAD project may require relocation of residents when properties undergo repairs, are demolished and rebuilt, or when the assistance is transferred to another site. PIH Notice 2012-32 REV-1 (see also FR Notice 5630-N-05, 78 FR 39759-39763 (July 2, 2013)) details RAD program requirements.

The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended, (URA) is a federal law that establishes minimum standards for federally-funded programs and projects that include the acquisition of real property (real estate) and/or displace persons from their homes, businesses, or farms as a result of acquisition, rehabilitation, or demolition of real property.[6] The URA will apply to acquisitions of real property and relocation of persons from real property that occurs as a direct result of acquisition, rehabilitation, or demolition for a project that involves conversion of assistance to Project-Based Voucher (PBV) or Project-Based Rental Assistance (PBRA) programs under RAD.

Additionally, all relocation conducted as part of a RAD conversion and all relocation assistance provided under URA must be consistent with applicable fair housing and civil rights laws, including, but not limited to, the Fair Housing Act, Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973.

Because each RAD proposal varies in its scope, this Notice may not address each PHA's specific circumstances. RAD PHAs and participants should carefully review the regulations, notices, and guidance material referenced in this Notice. Any questions related to the applicability of these requirements should be referred to the RAD Transaction Managers (TM) or may be emailed to rad@hud.gov.

3. Applicable Legal Authorities

[5] The term "resident" as used in this Notice refers to eligible resident families of public housing residing in a property applying for participation in RAD or a property that undergoes a conversion of assistance through RAD.

[6] HUD Handbook 1378 (Tenant Assistance, Relocation, and Real Property Acquisition), available at: http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/library/relocation/policyandguidance/handbook1378.

- RAD: Consolidated and Further Continuing Appropriations Act of 2012 (Public Law 112-55, approved November 18, 2011), with the implementing PIH Notice 2012-32, REV-1
- URA statute and implementing regulations: 49 CFR part 24
- FHEO: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Fair Housing Act
- Section 104(d) of the Housing and Community Development Act of 1974, statute and implementing regulations (if CDBG and/or HOME funds are used): 24 CFR part 42, subpart C

4. Relocation Planning

If there is a possibility that residents will be relocated as a result of acquisition, demolition, or rehabilitation for a project converting under RAD, PHAs must undertake a planning process in conformance with URA in order to minimize the adverse impact of relocation (49 CFR 24.205(a)).

While a written Relocation Plan is not a requirement under RAD or URA, the Department strongly encourages PHAs to prepare a written Relocation Plan, both to establish their relocation process and to communicate this process consistently and effectively to all relevant stakeholders. Appendix 1 contains recommended elements of a Relocation Plan.

The following presents a general sequencing of relocation planning activities within the RAD milestones:

Stage	Activities
1. Prior to submission of RAD application	• Determine potential need for relocation • Meet with residents to discuss plans, communicate right to return, and solicit feedback • Provide *General Information Notice* (GIN) to residents • Survey residents to prepare Relocation Plan and relocation process cost estimate
2. After receipt of the Commitment to Enter into a HAP Contract (CHAP) Award	• Prepare Significant Amendment to PHA Plan • Assess and refine need for relocation • Develop a Relocation Plan (See Appendix 1 for recommended content) • Identify relocation housing options
3. Preparing Financing Plan (due to RAD Transaction Manager no later than 180 days following	• Budget for relocation expenses • Submit FHEO Accessibility & Relocation checklist (PHAs may submit Relocation Plan along with checklist)

Stage	Activities
CHAP award)	
4. Receipt of RAD Conversion Commitment (RCC)	• The date of issuance of the HUD RCC marks the date of "Initiation of Negotiations" (ION), as defined in the URA (49 CFR 24.2(a)(15)) • Provide residents with appropriate notice informing them if they will be relocated and any associated relocation assistance • Meet with residents to describe approved conversion plans and discuss required relocation
5. Closing/RAD conversion	• Generally, resident relocation should not begin until after the date of closing/conversion of assistance under RAD • PHAs must adhere to notification requirements (described in Paragraph 8 of this Notice): generally, a minimum of 30 days for residents to be temporarily relocated for up to a year, and 90 days for permanent relocation • PHAs seeking to move residents prior to closing must receive prior approval from HUD as described in Paragraph 9 of this Notice

5. Resident Right to Return

RAD program rules prohibit the permanent involuntary relocation of residents as a result of conversion. Residents that are temporarily relocated retain the right to return to the project once it has been completed and is in decent, safe, and sanitary conditions.[7] The period during which residents may need to be temporarily relocated is determined by the period of rehabilitation or construction, which will be specific to each project.

If proposed plans for a project would preclude a resident from returning to the RAD project, the resident must be given an opportunity to comment and/or object to such plans. If the resident objects to such plans, the PHA must alter the project plans to accommodate the resident in the converted project. If a resident agrees to such plans, the PHA must secure informed, written consent from the resident to receive permanent relocation assistance and payments consistent with URA and acknowledge that acceptance of such assistance terminates the resident's right to return to the project. In obtaining this consent, PHAs must inform residents of their right to return, potential relocation, and temporary and permanent housing options at least 30 days before residents must make a decision. The PHA cannot employ any tactics to pressure residents into

[7] Where the transfer of assistance to a new site is approved, residents of the converting project will have the right to reside in an assisted unit at the new site once rehabilitation or new construction is complete.

relinquishing their right to return or accepting permanent relocation assistance and payments.[8] A PHA may not terminate a resident's lease if it fails to obtain this consent.

PHAs must keep documentation of such information provided to residents and such consent by residents. While HUD does not require PHAs to submit documentation of obtaining this consent, PHAs and participants must properly brief residents on their housing and relocation options and must keep auditable written records of such consultation and decisions. HUD may request this documentation during a review of the FHEO Relocation and Accessibility Checklist or if relocation concerns arise.

Examples of project plans that may preclude a resident from returning to the converted RAD project include, but are not limited to:

- Changes in bedroom distribution (i.e. when larger units will be replaced with smaller units such that current residents would become under-housed or when smaller units will be replaced with larger units such that current residents would become over-housed);
- Where a PHA is reducing the number of assisted units at a property by a de minimis amount[9], but those units are occupied by assisted residents; or
- The reconfiguration of efficiency apartments, or the repurposing of dwelling units in order to facilitate social service delivery.

In all scenarios where residents voluntarily accept permanent relocation to accommodate project plans, these residents are eligible for permanent relocation assistance and payments under URA. If a resident accepts permanent relocation assistance, the resident surrenders his or her right to return to the completed project.

6. Relocation Assistance

Under RAD, relocation assistance may vary depending on the length of time relocation is required.[10]

a. In instances when the PHA anticipates that a resident will be relocated for more than a year, the PHA must offer the resident the choice of:

- Permanent relocation assistance and payments at URA levels; or
- Temporary relocation assistance, including temporary housing, while the resident retains his or her right to return and reimbursement for all reasonable out-of-pocket expenses associated with the temporary relocation.

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8 Persons with disabilities returning to the RAD project may not be turned away or placed on a waiting list due to a lack of accessible units. Their accessibility needs must be accommodated.

9 A reduction in total number of assisted units at RAD project of 5% or less. (Section 1.5.B of PIH 2012-32 REV-1)

10 Some residents may not qualify for relocation assistance under URA. A nonexclusive listing of persons who do not qualify as displaced persons under URA is at 49 CFR 24.2(a)(9)(ii). See also, Paragraph 1-4(J) of HUD Handbook 1378.

The PHA must give the resident no less than 30 days to decide between permanent and temporary relocation assistance. If the resident elects to permanently relocate with assistance at URA levels, the PHA must inform the resident that his or her acceptance of permanent relocation assistance terminates the resident's right to return to the completed RAD project.

b. In instances when a resident elects temporary relocation assistance and reoccupies a unit in the completed project within one year, the resident need not be offered permanent relocation assistance pursuant to URA.

   Great care must be exercised to ensure that residents are treated fairly and equitably. If a resident is required to relocate temporarily in connection with the project, his or her temporarily occupied housing must be decent, safe, and sanitary and the resident must be reimbursed for all reasonable out-of-pocket expenses incurred in connection with the temporary relocation. These expenses include, but are not limited to, moving expenses and increased housing costs during the temporary relocation.

c. In the event that a resident elects to receive temporary relocation assistance and the temporary relocation exceeds one year, the resident becomes eligible for all permanent relocation assistance and payments under URA. (This assistance would be in addition to any assistance the person has already received for temporary relocation, and may not be reduced by the amount of any temporary relocation assistance.) In such event, the PHA shall give the resident the opportunity to choose to remain temporarily relocated for an agreed-to period (based on new information about when they can return to the completed RAD unit), or choose to permanently relocate with URA assistance.

   PHAs may not propose or request that a displaced person waive rights or entitlements to relocation assistance under the URA. If the resident elects to permanently relocate with URA assistance, the PHA must inform the person that the person's acceptance of URA relocation assistance to permanently relocate will terminate the person's right to return to the completed RAD project. Conversely, unless and until the resident elects to be permanently relocated, the resident may remain temporarily relocated with a right to return to the completed project.

7. Initiation of Negotiations (ION) Date

Eligibility for URA relocation assistance is generally effective on the date of initiation of negotiations (ION) (49 CFR 24.2(a)(15)). For RAD projects, the ION date is the date of the issuance of the RAD Conversion Commitment (RCC).

8. Resident Notification

When a project converting under RAD will include relocation of residents, notice must be provided to those resident households. For each notice listed below, one notice shall be given to each resident household. The purpose of these notifications is to ensure that residents are

informed of their potential rights and the relocation assistance available to them. During initial meetings with residents about RAD and in subsequent communications with residents related to relocation, the PHA should inform residents that if they choose to move after receiving a written GIN, but prior to receiving a RAD Notice of Relocation, they may jeopardize their eligibility for relocation assistance. However, PHAs should note that a resident move undertaken as a direct result of the project may still require relocation assistance and the resident may be eligible to receive permanent relocation assistance under the URA even though the PHA has not yet issued notices.

a. *General Information Notice* (49 CFR 24.203(a) & Handbook 1378, Paragraph 2-3(B))

As soon as feasible in the planning process, the PHA must provide each resident with a written GIN (see sample in Appendix 2) to provide a general description of the project, the activities planned, and the relocation assistance that may become available. URA regulations state that the GIN should be provided *as soon as feasible*. Under RAD, PHAs must provide GINs during the initial RAD resident meetings, before submitting a RAD application. GINs must do at least the following:

- Inform the resident that he or she may be displaced for the project and generally describe the relocation payment(s) for which the resident may be eligible, the basic conditions of eligibility, and the procedures for obtaining the payment(s);
- Inform the resident that he or she will be given reasonable relocation advisory services, including referrals to replacement properties, help in filing payment claims, and other necessary assistance to help the resident successfully relocate;
- Inform the resident that, if he or she qualifies for relocation assistance as a displaced person under the URA, he or she will not be required to move without at least 90 days advance written notice, and inform any person to be displaced from a dwelling that he or she cannot be required to move permanently unless at least one comparable replacement dwelling has been made available;
- Inform the resident that any person who is an alien not lawfully present in the United States is ineligible for relocation advisory services and relocation payments, unless such ineligibility would result in exceptional and extremely unusual hardship to a qualifying spouse, parent, or child (see 49 CFR 24.208(h) for additional information); and
- Describe the resident's right to appeal the PHA's determination as to a person's eligibility for URA assistance.

b. *RAD Notice of Relocation*

If a resident will be relocated to facilitate the RAD conversion, the PHA shall provide notice of such relocation (RAD Notice of Relocation). The PHA shall issue this notice upon the PHA's receipt of the RCC from HUD, which is the ION date.

If residents will not be relocated, notice of relocation is not required, but the PHA should

notify them that they are not being relocated.[11]

The RAD Notice of Relocation must conform to the following requirements:

- The notice must state the anticipated duration of the resident's relocation.
- PHAs must provide this notice a minimum of 30 days prior to relocation to residents who will be temporarily relocated.[12] Longer notice may be appropriate for persons who will be relocated for an extended period of time (over 6 months), or if necessary due to personal needs or circumstances.
- Residents whose temporary relocation is anticipated to exceed one year must be informed that they will have no less than 30 days to elect temporary or permanent relocation as described in Section 6 of this Notice. When timing is critical for project completion, the 30-day decision period can run concurrently with the 30-day notice period for temporary relocation and with the 90-day period for permanent relocation if the PHA makes available comparable replacement dwellings consistent with 24.204(a).
- Residents who will be permanently relocated must receive written notice a minimum of 90 days prior to relocation. This 90-day time period may only begin once the PHA has made available at least one comparable replacement dwelling consistent with 49 CFR 24.204(a).[13]
- The notice must describe the available relocation assistance, the estimated amount of assistance based on the individual circumstances and needs, and the procedures for obtaining the assistance. The notice must be specific to the resident and his or her situation so that the resident will have a clear understanding of the type and amount of payments and/or other assistance the resident household may be entitled to claim.
- The notice must explain the reasonable terms and conditions under which the resident may continue to lease and occupy a unit in the completed project.
- The notice must state that the PHA will reimburse the resident for all reasonable out-of-pocket expenses incurred in connection with any temporary move. These expenses include, but are not limited to, moving expenses and increased housing costs (rent, utilities, etc.).

c. *Notice of Intent to Acquire* (49 CFR 24.203(d))

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[11] HUD policy generally requires a "notice of non-displacement" in certain instances; the RAD program does not require this notice. Although the scope of this notice is limited to guidance for projects requiring relocation, PHAs should note, however, that there may be notification requirements for projects that do not involve relocation. The RAD conversion will terminate the resident's public housing lease and commence a PBV or PBRA lease, even when there is no relocation required. In such instances, state law may impose certain notification requirements. In addition, public housing regulations generally require 30 days' notice prior to lease termination. PHAs are encouraged to review public housing requirements set forth in 24 CFR parts 5 and 966.

[12] HUD may approve shorter notice periods based on an urgent need due to danger, health, or safety issues or if the person will be temporarily relocated for only a short period.

[13] PHAs should note that URA regulations also require, where possible, that three or more comparable replacement dwellings be made available before a resident is required to move from his or her unit.

For RAD projects involving acquisition, residents may be provided with a notice of intent to acquire ("*Notice of Intent to Acquire"*) prior to the ION date with HUD's prior approval. Once the Notice of Intent to Acquire is provided, a resident's eligibility for relocation assistance and payments is established. Therefore, the RAD Notice of Relocation must be provided in conjunction with or after the Notice of Intent to Acquire. A RAD Notice of Relocation would not otherwise be sent prior to the ION date.

Since residents who accept permanent relocation must receive 90 days advanced written notice prior to being required to move, providing residents the Notice of Intent to Acquire and RAD Notice of Relocation prior to the ION date may be necessary to provide sufficient notice of relocation to a resident in instances where there may not be 90 days between the issuance of the RCC (ION date) and the anticipated closing date. This allows the PHA to issue the notice earlier so that relocation may begin upon closing. This allows program participants to conduct orderly relocation upon closing, minimize adverse impacts on displaced persons, and to expedite project advancement and completion.[14]

d. *URA Notice of Relocation Eligibility – for residents whose temporary relocation exceeds one year* (49 CFR 24.203(b) & Handbook 1378, Paragraph 2-3(C))

After a resident has been temporarily relocated for one year, the PHA must provide a notice of relocation eligibility in accordance with URA requirements ("*Notice of Relocation Eligibility*"). This notice is not required if the resident has already accepted permanent relocation assistance.

The Notice of Relocation Eligibility must conform to URA requirements as set forth in 49 CFR Part 24, to HUD Handbook 1378 and to the following requirements:

- The PHA must provide updated information as to when it is anticipated that the resident will be able to return to the completed project.
- The resident may choose to remain temporarily relocated based upon such updated information or may choose to accept permanent URA relocation assistance in lieu of exercising the right to return.
- If the resident chooses to accept permanent URA relocation assistance and such assistance requires that the resident move, the URA requires such resident to receive 90 days advance written notice of the earliest date they will be required to move (i.e., 90-Day Notice, 49 CFR 24.203(c)). The PHA should be mindful that the 90-day time period may only begin once the PHA has made available at least one "comparable replacement dwellings" as set forth in 49 CFR 24.204(a).

9. Initiation of Relocation

[14] PHAs and program participants should note that, in most instances, it will be most appropriate for the acquiring entity to send this notice.

Unless otherwise approved by HUD, relocation may not begin until the date of closing of the RAD transaction and recordation of the RAD Use Agreement. PHAs must provide residents being temporarily relocated at least 30 days advance written notice of the required move. PHAs must give residents being permanently relocated at least 90 days advance written notice of the required move. This means PHAs are advised to plan carefully to account for this 30-day or 90-day notice period to ensure the closing is not delayed.

However, HUD is aware that, in rare cases, some project plans necessitate relocation prior to closing. With prior HUD approval, for projects involving acquisition, PHAs may relocate residents prior to the closing date subject to public housing requirements (see 24 CFR part 5 and 24 CFR 966). PHAs must contact their assigned RAD transaction manager (TM) to discuss plans as early as possible in the process to ensure compliance with all RAD and URA requirements.

If relocation prior to closing is desired, PHAs should submit to the TM the following information, as early as possible in the process:

- A written request for relocation prior to closing. The request must include justification of why the early relocation is necessary for the viability of the RAD transaction. Justification may include the presence of outside financing, such as Low Income Housing Tax Credit (LIHTC) awards, if the PHA can show that early relocation is necessary to meet critical LIHTC deadlines.
- FHEO Accessibility and Relocation Checklist.
- Evidence of intent to comply with public housing requirements, as applicable. Generally, public housing regulations require public housing residents to receive 30 days' notice prior to relocation and that such notice either be published in the PHA's admissions and continued occupancy policies (ACOP) or published elsewhere at least 30 days prior to receipt of such notice (24 CFR parts 5 and 966).

When seeking to relocate residents prior to closing, submission of this request as early as possible is preferred, prior to the 180-day Financing Plan milestone if possible (with Financing Plan submission following the request).

HUD reserves the right to request additional follow-up information, including a Relocation Plan and related budget, prior to approving such requests. PHAs must receive written HUD approval before beginning relocation of residents prior to closing.

Early planning and submission of the Financing Plan and FHEO checklist to HUD will ensure the PHA has built in the 30- or 90-day notice period prior to initiating relocation.

10. Fair Housing and Civil Rights Requirements

PHAs must comply with all applicable fair housing and civil rights laws, including, but not limited to, the Fair Housing Act, Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973, when conducting relocation planning and providing relocation assistance. Further, communication must be provided in a manner that is effective for persons

with disabilities (24 CFR 8.6) and for person who are Limited English Proficient (see 72 FR 2732). This section discusses some of the PHA's obligations under these laws and regulations. However, the applicability of civil rights laws is not limited to the activities discussed in this section. PHAs conducting relocation activities should familiarize themselves with applicable civil rights statutes, regulations, and guidance, including but not limited to, those listed at the end of this section.

- Effective Communication for Persons with Disabilities: Communications and materials must be provided in a manner that is effective for persons with hearing, visual, and other communication-related disabilities consistent with Section 504 of the Rehabilitation Act of 1973 (24 CFR 8.6), and as applicable, the Americans with Disabilities Act; and for persons who are limited English proficient (*see* 72 Fed Reg 2732). This includes ensuring that training materials are in appropriate alternative formats as needed, e.g., Braille, audio, large type, assistive listening devices, and sign language interpreters.

- Accessible Meeting Facilities for Persons with Disabilities: When holding public meetings, PHAs must give priority to methods that provide physical access to individuals with disabilities, i.e., holding the meetings, workshops, and briefings or any other type of meeting in an accessible location, in accordance with the regulations implementing Section 504 of the Rehabilitation Act of 1973 and Titles II and III of the Americans with Disabilities Act of 1990, as applicable. All programs and activities must be held in accessible locations unless doing so would result in an undue financial and administrative burden, in which case the PHA must take any action that would not result in such an alteration or such burden but would nevertheless ensure that individuals with disabilities receive the benefits and services of the program or activity, e.g., briefings at an alternate accessible, in-home briefing. Individuals with disabilities must receive services in the most integrated setting appropriate to their needs. The most integrated setting appropriate to the needs of qualified individuals with disabilities is a setting that enables individuals with disabilities to interact with nondisabled person to the fullest extent possible (28 CFR part 35, appendix B).

- Meaningful Access for Persons with Limited English Proficiency (LEP): PHAs must provide meaningful access to programs and activities for persons who have a limited ability to read, speak, or understand English. Any person with LEP who will be temporarily relocated or permanently displaced must have meaningful access to any public meetings regarding the project. In addition, any information provided to residents including, but not limited to, any notices required under the URA, should be provided in the appropriate language to persons with LEP. Generally, PHAs will be responsible for providing oral interpreters at meetings, including ensuring their competence, and covering any associated translation and interpretation costs.

- URA requires that PHAs provide persons who are unable to read or understand the notices, such as persons with disabilities or persons with LEP, with appropriate translation and counseling to ensure that they understand their rights and responsibilities and the assistance available to them (49 CFR 24.5). URA also requires that each notice indicate the name and telephone number of a person to contact with questions or for other

needed help (49 CFR 24.5). This notice should include the number for the telecommunication device for the deaf (TDD) or other appropriate communication device, if applicable (24 CFR 8.6(a)(2)).

- Comparable Housing for Persons with Disabilities: PHAs should identify the accessibility needs of residents to be relocated by consulting existing information (e.g., tenant characteristics forms, including identification of the need for accessible unit features; records of approved reasonable accommodations, and records of the presence of accessible unit features). For guidance on providing relocation assistance to persons with disabilities, see Exhibit 3-1 in HUD Handbook 1378.

- Advisory Services: PHAs should determine the advisory services that will be necessary to ensure a successful relocation program consistent with 49 CFR 24.205(c). Such advisory services may include housing counseling that should be facilitated to ensure that residents affected by the project understand their rights and responsibilities and the assistance available to them (49 CFR 24.205(c)). Advisory counseling must also inform residents of their fair housing rights and be carried out in a manner that satisfies the requirements of Title VI of the Civil Rights Act of 1964, the Fair Housing Act, and Executive Order 11063 (49 CFR 24.205(c)(1)). In addition, PHAs should inform residents that if they believe they have experienced unlawful discrimination, they may contact HUD at 1-800669-9777 (Voice) or 1-800-927-9275 (TDD) or at http://www.hud.gov.

Fair Housing References:

- Section 504 of the Rehabilitation Act of 1973
- Regulations: 24 CFR part 8
- Fair Housing Act Regulations: 24 CFR part 100
- Title VI of the Civil Rights Act of 1964
- Regulations: 24 CFR part 1
- Final Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (LEP Guidance) (72 FR 2732)
- Exhibit 3-1 Compliance with Section 504 of the Rehabilitation Act in HUD Handbook 1378 (Tenant Assistance Relocation and Real Property Acquisition)

11. Other Requirements

a. Public Housing Program Compliance
PHAs should note that public housing resident provisions related to occupancy and termination, including grievances and related hearings, will remain in effect until the execution of the new PBV or PBRA Housing Assistance Payment (HAP) contract.

b. Evictions for Cause
If the PHA determines that a resident was evicted in accordance with applicable state and local law for serious or repeated violation of material terms of the lease, and the eviction was not undertaken for the purpose of evading the obligation to make available URA payments and other assistance, the resident is not entitled to relocation payments and assistance under the URA (49 CFR 24.206).

Jemine A. Bryon
General Deputy Assistant Secretary
for Public and Indian Housing

Carol J. Galante, Assistant Secretary for
Housing-Federal Housing Commissioner

APPENDICES

Appendix 1
Recommended Relocation Plan Contents

Appendix 2
Sample RAD General Information Notice (GIN)

Appendix 3
Sample RAD Notice of Relocation (for relocation anticipated for a year or less)

Appendix 4
Sample RAD Notice of Relocation (for relocation anticipated for more than a year)

Appendix 5
Sample Notice of Eligibility for URA Relocation Assistance (for residents who have been temporarily relocated for more than a year)

Appendix 1: RECOMMENDED RELOCATION PLAN CONTENTS

While written Relocation Plans are not required under RAD or URA, the Department strongly encourages PHAs to document their relocation planning process and procedures in a written Relocation Plan. The following provides suggested content for Relocation Plans.

I. Project Summary

The Relocation Plan should provide a general description of and purpose for the project (e.g., year built, location, number of units, configuration, occupancy information, and funding sources).

The basic components of a plan include:

- A general description of the project and the site, including acquisition, demolition, rehabilitation, and construction activities and funding sources;
- A detailed discussion of the specific steps to be taken to minimize the adverse impacts of relocation, including when transferring the assistance to a new site;
- Information on occupancy (including the number of residents, residential owner-occupants and non-residential occupants, if any, to be permanently or temporarily relocated);
- Information on relocation needs and costs (including the number of residents who plan to relocate with Section 8 assistance);
- General moving assistance information;
- Temporary move assistance (including information on the duration of temporary moves);
- Permanent move assistance; and
- Appeals process.

II. Resident Return and Re-occupancy Policies

For residents that will be temporarily relocated, the plan should include the criteria that will be used to determine the priority for residents to re-occupy units at the project after rehabilitation, demolition, and/or construction is completed. For example, if units will come online in stages, the plan should outline how the PHA will determine when each resident will return to the project. PHAs should ensure that any written return or re-occupancy policy is compliant with related RAD requirements, such as the right-to-return policy and the "no re-screening upon conversion" policy, as described in the RAD Notice.

III. Summary of Moving Costs

The plan should include a summary of moving costs, identified by move types, including the following:

Temporary Moves

- Number of and cost amount for two-way moves (i.e., a move to another unit and then a return move) within the same building/complex.
- Number of and cost amount for two-way moves to a unit not in the same building/complex, carried out by the PHA.
- Number of and cost amount for two-way moves to a unit not in the same building/complex not carried out by the PHA.

Permanent Moves

- Number of and cost amount for one-time moves into another unit in the same building/complex.[15]
- Number of and cost amount for one permanent move to a unit not within the same building/complex, carried out by the PHA.
  PHAs should note that if a residential move is carried out by the PHA at no cost to the resident, this per-household estimate must include the required dislocation allowance (currently $100). The URA Fixed Residential Moving Cost Schedule lists the most current dislocation allowance:
  http://www.fhwa.dot.gov/real_estate/practitioners/uniform_act/relocation/moving_cost_schedule.cfm
- Number of and cost amount for one permanent move to a unit not within the same building/complex that is not carried out by the PHA.

IV. Temporary Relocation Assistance

The PHA will assist residents who are required to move temporarily. At the Initiation of Negotiations (ION), the PHA will send a RAD Notice of Relocation to residents who will be relocated. Appendices 3 and 4 of this Notice contain sample RAD Notices of Relocation to be provided to residents that will be temporarily relocated.

The plan should detail the temporary relocation assistance the PHA will provide for residents (Paragraph 2-7 of HUD Handbook 1378). This assistance includes:

- Temporary Housing - The PHA will provide temporary housing that is decent, safe, and sanitary on a nondiscriminatory basis for residents who are relocated temporarily. The PHA will also pay for reasonable increased housing costs that the resident incurs in connection with the temporary relocation.

  NOTE: If a resident's relocation exceeds one year, the PHA must then issue a *Notice of Relocation Eligibility* (49 CFR 24.203(b)) to the resident and offer the resident permanent

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15 A resident who moved to another unit in the same building/complex may be considered a displaced person under URA if the resident moves from the building/complex permanently and was not offered reimbursement for all reasonable out-of-pocket expenses incurred in connection with the move within the same building/complex and/or if other conditions of the move within the building/complex were not reasonable.

relocation assistance and payments at URA levels. The PHA must provide this notice to affected residents as soon as the temporary relocation exceeds one year.

- Packing and Moving Assistance - Since most residents prefer to pack their own personal possessions and items of value, they should be provided packing instructions, boxes, markers, and tape for the move. If assistance in packing is needed, the PHA should provide the resident with information on how to request this assistance. The PHA is responsible for covering all reasonable moving expenses incurred in connection with temporarily relocating a resident. The PHA may reimburse the resident's out-of-pocket moving expenses and/or directly carry out the move.

- Payment for Temporary Relocation Moving Expenses - The plan should also indicate how the PHA intends to provide or reimburse for moving services and expenses. The PHA can choose to do one or more of the following:
  – Undertake the moves itself, using force account labor or a moving company; – Use PHA's contractor or moving company;
  – Carry out moves with employees of the PHA;
  – Reimburse residents for all actual and reasonable moving costs.

  NOTE*:* The PHA will not make fixed payments since such payments may not be representative of actual reasonable costs incurred. However, in order for a resident to be sure of full reimbursement, the resident should submit a moving cost estimate to the PHA for approval prior to the move unless the PHA is directly carrying out the move and the resident will not incur any reasonable out-of-pocket moving expenses. Failure to do so may result in the resident not being fully reimbursed.

- Utility Costs - The PHA is responsible for covering the expenses relating to disconnection and reconnection of necessary utilities. If the resident has telephone, cable service or Internet access, the PHA is responsible for covering the expenses involved in transferring existing service. The PHA may also pay utility deposits, if required at the temporary relocation housing (HUD Handbook 1378, paragraph 2-7(A)(3)). If a resident is temporarily relocating from a public housing unit to a non-public housing unit, the resident must be reimbursed for reasonable increases in utility costs even if the PHA utility allowance is lower than the actual costs to the resident.

V. Permanent Relocation Assistance

Based on the local housing resources available, the PHA should identify the replacement housing options that will be available to meet the housing needs of residents to be permanently relocated. Replacement housing options for residents that meet the definition of a "displaced person" (49 CFR 24.2(a)(9)) under the URA include, but are not limited to:

- Other Public Housing;
- Section 8 Project-Based Voucher unit;
- Section 8 Housing Choice Voucher unit;
- Homeownership housing;

- Private-market rental housing (affordable, non-subsidized).[16]

The plan should describe each type of replacement housing projected to be available, including:

1. Number of units, by bedroom size, expected to be available, and discussion of whether available units will meet dwelling requirements of relocated residents;
2. General area or location of unit(s);
3. Criteria for receiving relocation assistance; and
4. Any other information that might benefit residents in their consideration of housing choices.

The plan should include a description of the permanent relocation assistance the PHA will provide to residents. This assistance includes:

- Availability of Comparable Replacement Housing – Under URA, no displaced resident will be required to move unless at least one comparable replacement dwelling (49 CFR 24.2(a)(6)) is made available at least 90 days before the required move (49 CFR 24.203(c)). Comparable replacement dwellings must contain the accessibility features needed by displaced persons with disabilities (49 CFR 24.2(a)(8)(vii); 49 CFR part 24, Appendix A, §24.2(a)(8)(vii)). If the comparable replacement dwelling is not subsidized housing, the PHA should contact the RAD staff for advice on replacement housing payment requirements.

- Referral to Housing Not Located in an Area of Minority Concentration - Whenever possible, minority persons shall be given reasonable opportunities to relocate to decent, safe, and sanitary replacement dwellings that are within their financial means and not located in areas of minority concentration (49 CFR 24.205(c)(2)(ii)(D)). However, this policy does not require a PHA to provide a person a larger payment than is necessary to enable a person to relocate to a comparable replacement dwelling unit.

- Permanent Relocation Moving Expenses from Public Housing to Public Housing - The PHA may choose one of the following options for covering the expenses involved in moving public housing residents that are relocated into other public housing:

  – Undertake the move itself, using force account labor or a moving company. Residents should incur no moving costs under this option, but if such expenses are incurred, the PHA is responsible for reimbursing the resident for any such actual and reasonable expenses. In such case, the resident is also entitled to a dislocation allowance (currently $100). The URA Fixed Residential Moving Cost Schedule lists the current dislocation allowance and is available at: http://www.fhwa.dot.gov/real estate/practitioners/uniform act/relocation/moving cost schedule.cfm

16 Every effort should be made to find another subsidized unit as replacement housing for a resident relocating from subsidized housing so that the resident will continue receiving the housing subsidy as long as it is needed.

NOTE: Residents who prefer to pack their own personal possessions and items of value may be provided packing instructions, boxes, markers, and tape for their move. If a resident needs assistance in packing, they should contact the PHA. It is the responsibility of the PHA to pack and move all of their belongings and household goods, if so desired.

 Allow the resident to elect one of the following choices:

1) The PHA will reimburse the resident for the cost of all actual reasonable and necessary moving and related expenses (49 CFR 24.301), such as:
   - Transportation of the resident and personal property. This may include reimbursement at the current mileage rate for personally owned vehicles that need to be moved. Transportation costs for a distance beyond 50 miles are not eligible, unless the PHA determines that relocation beyond 50 miles is justified.
   - Packing, crating, uncrating, and unpacking of personal property.
   - Storage of personal property for a period not to exceed 12 months, unless the PHA determines that a longer period is necessary.
   - Disconnecting, dismantling, removing, reassembling, and reinstalling relocated household appliances and other personal property.
   - Insurance for the replacement value of the property in connection with the move and necessary storage.
   - The replacement value of property lost, stolen, or damaged in the process of moving (not through the fault or negligence of the displaced person, his or her agent, or employee) where insurance covering such loss, theft, or damage is not reasonably available.

2) The PHA will pay directly to the resident the applicable and current fixed moving cost payment according to the URA Fixed Residential Moving Cost Schedule (49 CFR 24.302), available at: http://www.fhwa.dot.gov/real_estate/practitioners/uniform_act/relocation/moving cost schedule.cfm

 Permanent Relocation Moving Expenses for All Other Moves – Under URA, residents who are permanently displaced, except for those residents displaced from public housing and moving to other public housing, are entitled to the assistance described in the brochure *Relocation Assistance To Residents Displaced From Their Homes*, available in English at http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_16280.doc and in Spanish at http://portal.hud.gov/hudportal/documents/huddoc?id=DOC 16281.doc. Residents may choose moving assistance from one of the following two options.

1) The PHA will reimburse the resident for the cost of all actual reasonable moving and related expenses (49 CFR 24.301).

2) The PHA will pay directly to the resident the applicable and current fixed moving cost payment according to the URA Fixed Residential Moving Cost Schedule (49

CFR 24.302), available at:
http://www.fhwa.dot.gov/real estate/practitioners/uniform act/relocation/moving cost schedule.cfm.

- Replacement Housing Payment - In addition to covering moving expenses, displaced residents may be entitled to a replacement housing payment (RHP). This payment is intended to cover the increase, if any, in monthly housing costs for a 42-month period.

  When calculating the RHP, the PHA must consider the comparable replacement housing unit offered to the resident. Since the PHA is not required to pay an RHP amount that exceeds the amount of RHP calculated for the offered comparable replacement dwelling, residents are cautioned to work closely with the PHA prior to their move.

- Accessible Housing for Persons with Disabilities - Under the URA, persons with disabilities who will be permanently displaced must be relocated to a replacement dwelling that contains the accessibility features they need (49 CFR 24.2(a)(8)(vii); 49 CFR Appendix A, 24.2(a)(8)(vii)). A person with disabilities who has been relocated must be offered a comparable replacement dwelling unit that contains accessible features comparable to the housing from which the tenant has been displaced or relocated. This is so even if the tenant has paid for the acquisition and/or installation of accessible features in the housing from which he or she has been relocated; in such instances, the recipient must ensure that the replacement housing contains comparable accessible features or provide relocation assistance to the tenant in an amount that covers the cost of acquiring and/or installing comparable accessible features. Under the URA, an agency may use project funds to remove architectural barriers for displaced owners and tenants with disabilities or take other last resort housing measures if comparable replacement dwelling units are not available within the monetary limits prescribed under the URA regulations (49 CFR 24.404(c)(vii); HUD Handbook 1378, Paragraph 3-8).

VI. **Relocation Budget**

Based on the results of the planning process, the PHA should create a relocation budget that includes the following six components:

1) The cost of administering the plan and providing assistance and counseling.

2) Reasonable moving expenses for a person with disabilities, which may include the cost of moving assistive equipment that is the personal property of the residents, the furnishings and personal belonging of a live-in aide, and/or other reasonable accommodations (HUD Handbook 1378, Paragraph 3-2).

3) The cost of the physical move of the residents' belongings. (It is suggested that the move costs be broken down by average cost per move type multiplied by the number of moves.)
   NOTE: This physical move cost total should be based on the move scenarios anticipated

or projected by the resident survey.

4) The cost estimated to pay for projected increases in monthly housing costs for temporary relocation.

5) The cost estimated to pay for the replacement housing payment (RHP) (42-month period for URA or 60-month period if section 104(d) applies).

6) Contingency costs estimated for carrying out the relocation process necessary to complete the proposed project. (The PHA should state where these costs are indicated in the application, or attach any other information required by HUD, to support these costs.)

VII. Appeal Process

If a resident disagrees with the PHA's decision as to the resident's eligibility to receive relocation assistance, the amount of a relocation payment, or the adequacy of a comparable replacement dwelling offered to a resident, the resident may file a written appeal to the PHA. The Relocation Plan should describe the specific appeal procedures to be followed consistent with 49 CFR 24.10 (and 24 CFR 42.390 if section 104(d) is involved). At a minimum, the resident will have 60 days to file an appeal with the PHA after receiving written notification of a claim or ineligibility determination.

VIII. Certification

The plan should contain a certification of compliance with the URA and, if applicable, section 104(d).

Technical Assistance

The PHA should direct questions on this Notice's relocation assistance requirements to their RAD Transaction Manager or email rad@hud.gov.

Appendix 2: SAMPLE RAD GENERAL INFORMATION NOTICE (GIN)

PHA LETTERHEAD

RENTAL ASSISTANCE DEMONSTRATION (RAD)
GENERAL INFORMATION NOTICE (GIN)

[Date]

Dear [Resident Name],

The property you currently occupy is being proposed for participation in the Department of Housing and Urban Development's (HUD) Rental Assistance Demonstration (RAD) program. At this time, we expect that [the proposed acquisition, rehabilitation or demolition, may require you to be relocated (temporarily or permanently) from your unit]. We will provide further details to you as plans develop. **This notice does not mean that you need to leave the property at this time. This is not a notice of eligibility for relocation assistance.** The remainder of this letter only applies to situations where you will need to be relocated from your unit.

This notice serves to inform you of your potential rights under the RAD program and a federal law known as the Uniform Relocation Assistance and Real Property Acquisition Policies Act (URA). If the proposed RAD project receives HUD approval and if you are displaced permanently as a result, you may become eligible for relocation assistance and payments under the URA, including:

1) Relocation advisory services that include referrals to replacement properties, help in filing payment claims and other necessary assistance to help you successfully relocate;
2) At least 90 days' advance written notice of the date you will be required to move;
3) Payment for moving expenses; and
4) Payments to enable you to rent a similar replacement home.

NOTE: Aliens not lawfully present in the United States are not eligible for URA relocation assistance, unless such ineligibility would result in exceptional and extremely unusual hardship to a qualifying spouse, parent, or child as defined at 49 CFR 24.208(h). All persons seeking relocation assistance will be required to certify that they are a United States citizen or national, or an immigrant lawfully present in the United States.

As a resident of a property participating in RAD, you have the right to return to the project after the project is complete. You will be able to lease and occupy a unit in the converted project when rehabilitation is complete.

If you are permanently displaced from your home, you will not be required to move until you are given at least 90-day advance written notice of any required move and at least one comparable replacement dwelling has been made available to you. If you are temporarily relocated and your temporary relocation lasts more than one year, you will be contacted and offered permanent relocation assistance as a displaced person under the URA. This assistance would be in addition

to any assistance you may receive in connection with temporary relocation and will not be reduced by the amount of any temporary relocation assistance you have already received.

If you are required to relocate from the property in the future, you will be informed in writing. [PHA] will inform you of what assistance and payments you are eligible for if you will be relocated because of RAD and how you will receive these payments. If you become a displaced person, you will be provided reasonable assistance necessary to complete and file any required claim to receive a relocation payment. If you feel that your eligibility for assistance is not properly considered, you will also have the right to appeal a determination on your eligibility for relocation assistance.

You should continue to pay your rent and meet any other requirements specified in your lease. If you fail to do so, [PHA] may have cause for your eviction. If you choose to move, or if you are evicted, prior to receiving a formal notice of relocation eligibility, you may become ineligible to receive relocation assistance. It is very important for you to contact us before making any moving plans.

You will be contacted soon so that we can provide you with more information about the proposed project. If the project is approved, we will make every effort to accommodate your needs. In the meantime, if you have any questions about our plans, please contact: [Name, Title, Address, Phone, Email Address]. This letter is important to you and should be retained.

Sincerely,

[Name]
[Title]

NOTES:

1. Files must indicate how this notice was delivered (e.g., personally served or certified mail, return receipt requested) and the date of delivery. (49 CFR 24.5 and Paragraph 2-3(J) of Handbook 1378)
2. This is a sample GIN. PHAs should revise it to reflect project-specific circumstances.
3. PHAs may provide residents with HUD brochure "Relocation Assistance To Residents Displaced From Their Homes" available at: http://www.hud.gov/offices/cpd/library/relocation/publications/1042.pdf.

Appendix 3: SAMPLE RAD NOTICE OF RELOCATION (For relocation anticipated for a year or less)

THIS IS A GUIDE FORM.
REVISE TO REFLECT THE PROJECT-SPECIFIC CIRCUMSTANCES.

PHA Letterhead

(date)

Dear [*Resident Name*],

The property you currently occupy is participating in the Department of Housing and Urban Development's (HUD) Rental Assistance Demonstration (RAD) program. On [*date*], the [*Public Housing Authority*] (PHA) notified you of proposed plans to [acquire/ rehabilitate/demolish] the property you currently occupy at [*address*]. On [*date*], HUD issued the RAD Conversion Commitment (RCC) and committed federal financial assistance to the project. [*In instances where a Notice of Intent to Acquire is applicable and this notice is being sent before the RCC is issued, in lieu of the previous sentence noting the RCC issuance date, insert:* [*Name of entity acquiring the property*] (Displacing Agency) intends to acquire the property you currently occupy. **This is a Notice of Intent to Acquire.**]

In order for PHA to complete the project, you will need to be relocated for [*anticipated duration of relocation*]. Upon completion of the project, you will be able to lease and occupy your present unit or another decent, safe and sanitary unit in the completed project under reasonable terms and conditions. You are eligible for relocation payments and assistance.

However, **you do not need to move now.** This notice informs you that a decent, safe, and sanitary dwelling unit, listed below, has been made available to you and you will be required to move by [*insert date at least 30 days after the date of this notice*].

If your temporary relocation exceeds one year and you qualify as a "displaced person" under the Uniform Relocation Assistance and Real Property Acquisition Policies Act (URA), you may be eligible for further relocation assistance and payments under URA.

NOTE: Aliens not lawfully present in the United States are not eligible for URA relocation assistance, unless such ineligibility would result in exceptional and extremely unusual hardship to a qualifying spouse, parent, or child as defined at 49 CFR 24.208(h). All persons seeking relocation assistance will be required to certify that they are a United States citizen or national, or an alien lawfully present in the United States.

The relocation assistance to which you are entitled includes:

- Payment for Moving Expenses. You are entitled to be reimbursed for all reasonable out-of-pocket expenses incurred in connection with any temporary

move. [*PHA should list the form of payment for moving expenses selected in accordance with Appendix 1, Section 4 of this Notice.*]

- ☐ The location of your temporary replacement unit is [*address*]. This temporary housing has been determined to be decent, safe and sanitary.

- ☐ [*List appropriate relocation advisory services and any other services and assistance provided.*]

If you disagree with this determination, you may file a written appeal to the PHA in accordance with 49 CFR 24.10.

If you have any questions about this notice and your eligibility for relocation assistance and payments, please contact [*Name, Title, Address, Phone, Email Address*] before you make any moving plans. He/she will assist you with your move to a temporary unit and help ensure that you preserve your eligibility for any relocation payments to which you may be entitled.

Remember, do not move or commit to the purchase or lease of a replacement home before we have a chance to further discuss your eligibility for relocation assistance. This letter is important to you and should be retained.

Sincerely,

_____

Print name:
Title:

NOTE: The case file must indicate the manner in which this notice was delivered (e.g., personally served or certified mail, return receipt requested) and the date of delivery. (See 49 CFR 24.5 and Paragraph 2-3(J) of Handbook 1378.)

Appendix 4: SAMPLE RAD NOTICE OF RELOCATION (For relocation anticipated for more than a year)

THIS IS A GUIDE FORM.
REVISE TO REFLECT THE PROJECT-SPECIFIC CIRCUMSTANCES.

PHA Letterhead

(date)

Dear [*Resident Name*],

The property you currently occupy is participating in the Department of Housing and Urban Development's (HUD) Rental Assistance Demonstration (RAD) program. On [*date*], the [*Public Housing Authority*] (PHA), notified you of proposed plans to [acquire/ rehabilitate/demolish] the property you currently occupy at [*address*]. On [*date*], HUD issued the RAD Conversion Commitment (RCC) and committed federal financial assistance to the project. [*In instances where a Notice of Intent to Acquire is applicable and this notice is being sent before the RCC is issued, in lieu of the previous sentence noting the RCC issuance date, insert:* [*Name of entity acquiring the property*] (Displacing Agency) intends to acquire the property you currently occupy. **This is a Notice of Intent to Acquire.**]

In order for PHA to complete the project, you will need to be relocated for [*anticipated duration of relocation*]. Upon completion of the project, you will be able to lease and occupy your present unit or another decent, safe and sanitary unit in the completed project under reasonable terms and conditions. You are eligible for relocation assistance and payments. Because we expect your relocation to exceed one year, you have the choice to either:

- Receive temporary relocation assistance and return to a unit in the RAD project once it is complete; or
- Receive permanent relocation assistance and payments consistent with the URA instead of returning to the completed RAD project.

You must inform us of your choice within 30 days.

However, **<u>you do not need to move now.</u>** If you choose temporary relocation assistance, you will not be required to move sooner than 30 days after you receive notice that a temporary unit is available for you. If you choose permanent relocation assistance, you will not be required to move sooner than 90 days after you receive written notice that at least one comparable replacement unit is available to you in accordance with 49 CFR 24.204(a). [*Note to PHA: These time periods may start running as of the date of this Notice if the notice of relocation includes such information on the temporary and/or comparable replacement dwelling options, as applicable. In such circumstance, add applicable sentences to adequately notify the resident. For example:* This notice informs you that a temporary unit, listed below, has been made available to you and, if you choose this option, you will be required to move by [*date no sooner than 30 days after notice*]. This notice informs you

that a comparable unit, listed below, has been made available to you and, if you choose this option, you will be required to move by [*date no sooner than 90 days after notice*].]

If you choose temporary relocation, your relocation exceeds one year and you qualify as a "displaced person" under the Uniform Relocation Assistance and Real Property Acquisition Policies Act (URA), you may become eligible for further relocation assistance and payments under URA.

NOTE: Aliens not lawfully present in the United States are not eligible for URA relocation assistance, unless such ineligibility would result in exceptional and extremely unusual hardship to a qualifying spouse, parent, or child as defined at 49 CFR 24.208(h). All persons seeking relocation assistance will be required to certify that they are a United States citizen or national, or an alien lawfully present in the United States.

If you choose to receive temporary relocation assistance, this assistance will include:

- Payment for Moving Expenses. You are entitled to be reimbursed for all reasonable out-of-pocket expenses incurred in connection with any temporary move. [*PHA should list the form of payment for moving expenses selected in accordance with Appendix 1, Section 4 of this Notice.*]

- The location of your temporary replacement unit is [*address*]. This temporary housing has been determined to be decent, safe and sanitary.

- [*List appropriate relocation advisory services and any other services and assistance provided.*]

If you elect to receive permanent relocation assistance, this assistance will include:

- Relocation Advisory Services. You are entitled to receive current and continuing information on available comparable replacement units and other assistance to help you find another home and prepare to move.

- Payment for Moving Expenses. [*PHA should list the form of payment for moving expenses selected in accordance with Appendix 1, Section 5 of this Notice.*]

- Replacement Housing Payment. You may be eligible for a replacement housing payment to rent or buy a replacement home. The payment is based on several factors including: (1) the monthly rent and cost of utility services for a comparable replacement unit, (2) the monthly rent and cost of utility services for your present unit, and (3) 30% of your average monthly gross household income. This payment is calculated on the difference between the old and new housing costs for a one-month period and multiplied by 42.

- [*PHA: list here any permanent relocation assistance offered, such as a Housing Choice Voucher.*]

- ☐ Listed below are three comparable replacement units that you may wish to consider for your replacement home. If you would like, we can arrange transportation for you to inspect these and other replacement units.

	Address	Rent & Utility Costs	Contact Info
1.			
2.			
3.			

We believe that the unit located at [*address*] is most representative of your original unit in the converting RAD project. The monthly rent and the estimated average monthly cost of utilities for this unit is [$ *amount*] and it will be used to calculate your maximum replacement housing payment. Please contact us immediately if you believe this unit is not comparable to your original unit. We can explain our basis for selecting this unit as most representative of your original unit and discuss your concerns.

Based on the information you have provided about your income and the rent and utilities you now pay, you may be eligible for a maximum replacement housing payment of approximately [$ (42 x monthly amount)], if you rent the unit identified above as the most comparable to your current home or rent another unit of equal cost.

Replacement housing payments are not adjusted to reflect future rent increases or changes in income. This is the maximum amount that you would be eligible to receive. If you rent a decent, safe and sanitary home where the monthly rent and average estimated utility costs are less than the comparable unit, your replacement housing payment will be based on the actual cost of that unit. All replacement housing payments must be paid in installments. Your payment will be paid in [#] installments.

You may choose to purchase (rather than rent) a decent, safe and sanitary replacement home. If you do, you would be eligible for a down-payment assistance payment which is equal to your maximum replacement housing payment, [$*amount*.] [*PHAs should note that, at the agency's discretion, a down-payment assistance payment that is less than $5,250 may be increased to any amount not to exceed $5,250. (See 49 CFR 24.402(c)(1)).*] Let us know if you are interested in purchasing a replacement home and we will help you locate such housing.

Please note that all replacement housing must be inspected in order to ensure it is decent, safe and sanitary before any replacement housing payments are made.

If you have any questions about this notice and your eligibility for relocation assistance and payments, please contact [*Name, Title, Address, Phone, Email Address*] before you make any moving plans. He/she will assist you with your move to a new home and help ensure that you preserve your eligibility for all relocation payments to which you may be entitled.

Remember, do not move or commit to the purchase or lease of a replacement home before we have a chance to further discuss your eligibility for relocation assistance. This letter is important to you and should be retained.

Sincerely,

_____

Print name:
Title:

Enclosure/s

NOTE: The case file must indicate the manner in which this notice was delivered (e.g., personally served or certified mail, return receipt requested) and the date of delivery. (See 49 CFR 24.5 and Paragraph 2-3(J) of Handbook 1378.)

Appendix 5: SAMPLE NOTICE OF ELIGIBILITY FOR URA RELOCATION ASSISTANCE (For residents who have been temporarily relocated for more than a year)

THIS IS A GUIDE FORM.
IT SHOULD BE REVISED TO REFLECT THE CIRCUMSTANCES.

PHA Letterhead

(date)

Dear [*Resident*]:

The property you formerly occupied at [*address*] is participating in the Department of Housing and Urban Development's (HUD) Rental Assistance Demonstration (RAD) program. You have been temporarily relocated from that property since [*date*.] Your temporary relocation has exceeded one year.

It has been determined that you qualify as a "displaced person" according to the Uniform Relocation Assistance and Real Property Acquisition Policies Act (URA). You are eligible for relocation assistance and payments under the URA.

You may choose to remain temporarily relocated and return to a unit in the RAD project once it is completed. It is currently estimated that you may return to the RAD project by [*date*]. If you choose to remain temporarily relocated, you will stay at your current location until the RAD project is completed.

Alternatively, you may choose permanent relocation assistance and payments for which you are eligible, as listed below. If you choose permanent relocation assistance, you give up your right to return to the completed RAD project. However, **you do not need to move now.** If you choose permanent relocation assistance instead of exercising your right to return to the completed RAD project, you will not be required to move sooner than 90 days from the date that at least one comparable replacement unit has been made available to you. [*Alternatively:* You will not be required to move sooner than 90 days from the date of this notice, which informs you of a comparable replacement unit that has been made available for you].

This is your Notice of Eligibility for relocation assistance.

The effective date of your eligibility is [*insert date that relocation exceeds one year*.]

NOTE: Aliens not lawfully present in the United States are not eligible for URA relocation assistance, unless such ineligibility would result in exceptional and extremely unusual hardship to a qualifying spouse, parent, or child as defined at 49 CFR 24.208(h). All persons seeking relocation assistance will be required to certify that they are a United States citizen or national, or an alien lawfully present in the United States.

Enclosed is a brochure entitled, "Relocation Assistance to Tenants Displaced From Their Homes." Please read the brochure carefully. It explains your rights and provides additional information on eligibility for relocation payments and what you must do in order to receive these payments.

The relocation assistance to which you are entitled includes:

- Relocation Advisory Services. You are entitled to receive current and continuing information on available comparable replacement units and other assistance to help you find another home and prepare to move.

- Payment for Moving Expenses. [*PHA should list the form of payment for moving expenses selected in accordance with Appendix 1, Section 5 of this Notice.*] This is in addition to any amounts received to reimburse for any reasonable out-of-pocket expenses incurred in connection with the temporary move.

- Replacement Housing Payment. You may be eligible for a replacement housing payment to rent or buy a replacement home. The payment is based on several factors including: (1) the monthly rent and cost of utility services for a comparable replacement unit, (2) the monthly rent and cost of utility services for your present home, and (3) for low-income persons, 30 percent of your average monthly gross household income. This payment is calculated on the difference between the old and new housing costs for a one-month period and multiplied by 42.

- [*PHA list here any other relocation assistance offered the resident, such as Housing Choice Voucher* .]

Listed below are three comparable replacement units that you may wish to consider for your replacement home. If you would like, we can arrange transportation for you to inspect these and other replacement units.

	Address	Rent & Utility Costs	Contact Info
1.			
2			
3			

We believe that the unit located at [*address*] is most representative of the original unit you occupied in the converting RAD project. The monthly rent and the estimated average monthly cost of utilities for this unit is $[*amount*] and it will be used to calculate your maximum replacement housing payment. Please contact us immediately if you believe this unit is not comparable to your original unit. We can explain our basis for selecting this unit as most representative of your original unit and discuss your concerns.

Based on the information you have provided about your income and the rent and utilities you now pay, you may be eligible for a maximum replacement housing payment of approximately $ [42 x $Amount], if you rent the unit identified above as the most comparable to your current home or rent another unit of equal cost.

Replacement housing payments are not adjusted to reflect future rent increases or changes in income. This is the maximum amount that you would be eligible to receive. If you rent a decent, safe and sanitary home where the monthly rent and average estimated utility costs are less than the comparable unit, your replacement housing payment will be based on the actual cost of that unit. All replacement housing payments must be paid in installments. Your payment will be paid in [#] installments.

Should you choose to purchase (rather than rent) a decent, safe and sanitary replacement home, you would be eligible for a downpayment assistance payment which is equal to your maximum replacement housing payment, [$ *amount*] [*PHAs should note that, at the agency's discretion, a downpayment assistance payment that is less than $5,250 may be increased to any amount not to exceed $5,250. (See 49 CFR 24.402(c)(1)).*] Let us know if you are interested in purchasing a replacement home and we will help you locate such housing.

Please note that all replacement housing must be inspected in order to ensure it is decent, safe, and sanitary before any replacement housing payments are made.

If you have any questions about this notice and your eligibility for relocation assistance and payments, please contact [Name, Title, Address, Phone, Email Address] before you make any moving plans. He/she will assist you with your move to a new home and help ensure that you preserve your eligibility for any applicable relocation payments.

Remember, do not move or commit to the purchase or lease of a replacement home before we have a chance to further discuss your eligibility for relocation assistance. This letter is important to you and should be retained.

Sincerely,

_____

Print Name:
Title:

Enclosure/s

NOTE: The case file must indicate the manner in which this notice was delivered (e.g., personally served or certified mail, return receipt requested) and the date of delivery. (See 49 CFR 24.5 and Paragraph 2-3(J) of Handbook 1378.)

PUBLIC NOTICE

A Public Meeting to cover the Housing Authority of Clackamas County's (HACC) Annual Plan effective 2020-2021 was be held on January 16th, 2020, at 11AM at Oregon City View Manor Community Center, 200 S. Longview Way, Oregon City, OR 97045. Resident Advisory Board members and Public Housing residents were encouraged to attend.

During the ongoing coronavirus pandemic, your Board of County Commissioners is keeping the public/stakeholders as aware of decisions, and as connected to them, as possible. While social distancing practices are occurring, the Board of County Commissioners is holding meetings virtually. All residents are invited to join and provide comments live. Prior to each meeting our Public & Government Affairs staff will provide a Zoom Technology link for the members of the public to speak live on topics and public hearings that will be available on our website https://www.clackamas.us/news/2020-03-25/joining-the-board-of-county-commissioners-during-a-zoom-meeting. Alternatively, anyone can send in a comment to be read during the Citizen Communication portion of our meeting over email. Just send it in at any time during the meeting by emailing Elizabeth Miller at emiller@clackamas.us. As normal, meetings will be archived on our YouTube Channel. Thursday Business Meetings will continue to be livestreamed to YouTube, for all to watch.

HACC may convert its Public Housing properties to Rental Assistance Demonstration (RAD), as a result of the conversion, Capital Grant funding will be reduced by approximately $894,204/year. HACC may utilize the Replacement Housing Funds (RHF) in the amount of $147,421, to facilitate RAD conversion.

HACC developed its Plan in compliance with the Quality Housing and Work Responsibility Act of 1998 and Federal Register, Docket No. FR-4829-N-01.

The Draft Plan was available for review from January 20, 2020 - March 5th, 2020 and can be found online at https://www.clackamas.us/housingauthority/plansandreports.html. Written comments were directed to Elizabeth Miller, Housing Authority of Clackamas County, P.O. Box 1510, Oregon City, OR 97045, or by email at emiller@clackamas.us. These comments must have been received by March 5th, 2020.

Attachment K

HACC ANNUAL PLAN 2020-2021
Resident Advisory Board Meeting Agenda

Thursday, January 16, 2020 11am – 2pm at Oregon City View Manor Community Center

11:00-11:10 Welcome & Introductions

11:10-11:25 Annual Plan Review – New Activities & Progress Report

We are in a housing crisis and we really need your input, our goal is to help those who have the highest need. We ask that you keep that in mind during today's meeting because we will be talking about policies that may be controversial

Q: Are you changing from PH to S8?
A: Every person that lives in Public Housing during RAD conversion or disposition will get a voucher for as long as you need it. The voucher is administered by HACC. They are tenant protection vouchers.

You will pay between 30-40% of income, towards rent. Overall it is a similar rent structure. The difference is, you will have the opportunity to move anywhere in the county, but you will have to find your own housing location. We are developing lots of housing, but not Public Housing. We will more than double what we have now

- New activities, disposition, extensive planning project that has wrapped up, and a Clackamas Heights grant that we gave back, and no formal plans at this time.
- RAD = Rent Assistance Demonstration
- We have 145 scattered sites, mostly duplex and single family homes. In 2020 we will relocate folks and work with them to relocate or purchase a home (if eligible).
- For every unit we eliminate, we will bring back that unit plus more

Q: How do we do that?
A: $116.2 million will flow through HACC into Clackamas County over seven years. In one week we will be issuing through a Request for Proposal. We set aside 200 PBV to insert into those communities.

Some additional new activities include:

1. Kaiser and Heathshare are providing HACC with $1.3 million to provide 80 homeless disabled elderly with this money through the pilot program.
    - Health systems are investing in housing, for better patient outcomes if folks are housed.
    - There are going to be referring agencies that we have not determined yet
    - Will pull names from the Coordinated Housing Access Line (CHA) and receive referrals from service providers.

Q: Who are the 80 to receive the grant?
A: The priority is to serve those who are homeless and medically vulnerable.

2. New vouchers- 50 Mainstream and 15 –PBV
3. We currently have 7 applications and can serve up to 25 foster youth vouchers—3 year time limit for rent assistance. The idea is to get foster youth in stable housing.
   - These come with case management and wrap around services
4. Rosewood station:
   - 212 (20 PBV) affordable units to those making 60% of Area Median Income or less

Q: Homelessness—what is out definition for homelessness?
A: HUD defines homeless in several different categories: Literally Homeless (living on the street or a place not meant for habitation), Imminent risk of homeless (imminently lose housing with 14 days), Unaccompanied youth and those fleeing DV.

5. 18000 Webster rd. (acquired through Metro bond funds) it will be a very substantial overhaul to turn it into affordable housing –These will be for those 55 and over with 11 for high needs people.

11:25-11:40 Development Update

Hillside Park:
The community vision for us and our stakeholders, was to take the site and redevelop it.

- The Master Plan is complete.
- HACC is working with the City of Milwaukie on Land Use and next steps.
- The master plan shows additional units on the Hillside Park property
- Metro bond resources is our primary source of funding
- The Master Plan will be phased over 7 years, and is estimated to start early to mid-2021 (depending on approvals)
- These are complicated systems, and we are trying to find easier paths, but with so many stakeholders these things take time.

Q: Resident heard a rumor that funding for Hillside Manor came through but not Hillside Park, is this true?
A: We have to get HUD approval to go through with Hillside Park, but we have money set aside for that project, we just haven't started the HUD approval process. Over the next year we will be finalizing the application with HUD and the land use process with the City of Milwaukie

Q: And do you have a plan of where you will start with Hillside Park?
A: We are likely starting on Meek Street, going east to west on 32nd. As I mentioned this will be years away, but check for updates on our website. Our goal is to redevelop and realign to get closer to resources people who need it the most

Oregon City View Manor:

- HACC is still working with HUD on a Section18 Demolition/Disposition application
- Estimated to move forward over the next few years

Scattered Sites:

- These units are costly, widely dispersed
- Our vision is to pursue Section18 Demolition/Disposition with HUD
- Potential to create first time homebuyers program for those living in Public Housing and are interested and eligible. We are in housing crisis and this will create an affordable way for residents to become homeowners

- We may choose to sell some of those scattered sites and leverage those funds to build even more sites.

Q: Are you saying you are going to offer these to those willing to buy it if they can pay for it?
A: Yes, this is our goal, but they would have to qualify for the loan and be able to pay the monthly payments. This is for those who live in scattered sites. We are in talks with Proud Ground and Nedco to discuss partnering to help folks with low interest loans. We are changing our FSS program, and the money goes into an account for folks to be able to save for a down payment.

Metro Affordable Housing Bond:
- $116 million
- Release our funding to Developers through a Request for Proposals
- Seeking developers housing proposals to build in Clackamas County
- 800 units over 7 years
- 49% of the funds will go to those who need it most (0-30% of area medium income)

Q: When Rosewood Station opens, how many vouchers will be available?
A: Rosewood will be an affordable housing development. 10% of units are project based vouchers (PBV), and the others are tenant based vouchers. Section 8 income requirements are at or below 50% of Area Median Income:

Q: How many people are we going to house after the Hillside Park redevelopment?
A: We will be going from 200 households to closer to 600 households. We are working with the city of Milwaukie to get the parking figured out.

Q: Currently we have cell phone signal problems due to the metal siding and roofs. Will the new buildings be different?
A: New units will have better connectivity and everything prewired for maximum choice. We want to be very proactive about hearing from you and letting us know how we can provide choices to you and others in the community, that way you don't have to decide on whether you can afford to pay rent, or buy food for your family.

11:40-12:00 Public Housing Updates - Review Attachment B

Toni discussed proposed Policy Changes for Public Housing

Chapter 3: Family & Household:
- We are proposing to clarify language around families and households.
- Two or more individuals who are not related by blood, marriage, adoptions, other operation of law, but who either can demonstrate that they have lived together previously or certify that each individual's income and other resources will be available to meet the needs of family.
- Each family must identify the individuals to be included in the family at the time of application, and must update this information if the family's composition changes.

Chapter 3: Screening:
- Changing screening criteria, so we will begin checking landlord references two years, from five years.

Chapter 4: Family & Household:

- Each family must provide information and update information on family size when applying

Q: If a child is 18 years old, moves out and wants to move back in can they?
A: Section 8 gives up to 6 months for a previous household member to be added back to the household. If it is longer than that, they are not allowed. They will have to apply for housing for themselves as adults.

Chapter 4: Applying for Assistance:
- We are opening the Public Housing and Section 8 waitlists by April

Q: How do you notify public about waitlist opening?
A: we will give over a month notice, and this will go out to the public, the news, through email blast, and on our website. You can apply online, or a paper application (if requested in writing ahead of time). The waitlist will only be open a few days. The waitlist are lottery, so if you apply you may not be chosen

Q: We are opening up Public Housing waitlist even though you mentioned you are doing away with PH?
A: Yes, but then those property will transition to affordable, where our clients will be able to transition to a Tenant based or a PBV list. Applicants are added to the waitlist through a lottery system, so just because you apply, doesn't mean you'll be randomly selected through the lottery.

Chapter 4: Organizing the Waiting list:
- We currently have 18 Public Housing waitlists
- Our goal is to change it to a single waitlist, and we are proposing this to HUD. This offers faster hosing and more options.
- Currently one person can be on a waitlist for a 2 bedroom at one site-based waitlist, and has been on the waitlist for 3 or more years. Then when a 2 bedroom opens up and it is in a different location, someone else who may have only been on the waitlist for a year may have the opportunity to have that place, and not the first person simply because we have too many waitlists.

Chapter 4: Homeless Preference:
- Adding and Implementing a homeless preference to Public Housing
- Homeless preference referrals can come from service providers, in addition to the Coordinated Housing Access waitlists.

Chapter 5: Determining Unit Size:
- In an effort to serve more people with the money we receive, we need to tighten the occupancy standards, of 2 per bedroom. It would be 2 per bedroom regardless of age, gender, generational difference etc. The exception would be evaluated through reasonable accommodations.
- This would be a policy change moving forward, so for new households and for those on the transfer list.
- When clients are transitioning due to RAD, a resident will receive the voucher they are eligible for not what size Public housing unit they currently have. This aligns the two policies, to ease the transition.
- HACC is changing it, if you are too large of a family for our PH units, you will be denied, you must meet our occupancy standards or you will be denied.

Q: What about a child who is 16?
A: Age 16 and over means just another adult in house hold

Q: What about adding grandparents?
A: It is a waiver process to be added.

Chapter 6: Child Care Expense

- Aligns with new Section 8 proposed policies, which allows child care expenses for disabled children over 13 years old

Chapter 9: Conducting Annual reexaminations

- Aligns with Section 8, requiring families to self-report any criminal activity in the household form the previous year. HACC checks everyone (15 yrs or older) to see if they are a sex offender. Section 8 changed this to ask a question on our Annual Paperwork. If we find out that someone did not self-report properly, then we will handle that as a separate process.
- Residents are required to report income within 7 days of any change.
- We are proposing to further define what circumstances would initiate an Interim Exam.

Q: What if a member of the household receives a DUII?
A: you will need to mark yes on the form

Chapter 9: Required Reporting

- Adding new FSS language, regarding when an increase is due to earned income that will result in an increase in escrow credit.

Chapter 13: Over Income Families

- HUD says we can choose if we want our clients to either stay on Public Housing to have households move out of PH. HACC is choosing to have families move out of PH.
- This allows HACC to serve the most vulnerable lowest income families.

Q: When a resident gets higher income, don't you get the option to go to a fair market rent?
A: When we do the annual and you choose flat rent, they are on this for 3 years, unless they lose their job, or their income really changes.

12:00-12:30 Break for Lunch

12:30-1:00 Section 8 Updates - Review Attachment A

Toni discussed proposed Policy Changes for Section 8

Chapter 3: Family & Household

- Discussed above under Public Housing Attachment B

Chapter 4: Targeted Funding
Foster Youth Initiative (FYI), we applied for the family unification grant, this is what we offer, and this is what we have, the FYI serves youth for 36 months from foster care.

Q: Do they get peer support?
A: Yes through DHS

Chapter 4: Selection Method

- A preference puts you on top of the waitlist
- We are proposing to take that language off to transfer from one program to another, these are families who have an emergency and need a transfer, are over housed or under-housed etc.
- Reasonable accommodation- max of 33 referred by Social Services that met the definition of disabled.

- We removed the requirement that a client must be a Continuum of Care (CoC), Permanent Supportive housing (PSH) provider as this was a barrier to many clients.

Chapter 5: Determining Family Unit Size
- Discussed above under Public Housing Attachment B

Chapter 6: Child Care Expense Deduction
- Discussed above under Public Housing Attachment B

Chapter 10: Housing Assistance Payments
- We are currently able to use and overlap of funds for landlords, now you can have an overlap on the month you are moving.

Chapter 10: Zero HAP
- If a household has reach zero HAP, then they can stay 180 days, then they graduate. This is a HUD requirement. Most people choose to graduate off section 8 so they can be off all assistance.

Chapter 11: Required Reporting Remained Unchanged
- Mid-year change was not adopted

Chapter 16: Updating Payment Standards
- HACC will be updating payments standards by area to encourage lease up in low poverty census tracts change was not adopted

Chapter 17: Rent Limits
- To save funds, HACC put a cap on rents.
- There is an exception, if the project is going to serve a homeless or other high risk person
- Originally on waitlist---we are rewriting this, and new language is going thru CHA, through an agency, then they give us the referral.

Discussed overall staffing changes:
- Rich has transitioned to an Asset Manager only. Toni is taking over Public Housing, so Toni will be in charge of both Rent Assistance programs and Public Housing
- As our portfolio grows, asset mgmt. is more necessary.

1:00-1:20 Capital Fund Overview: Attachment H-I

<u>2019 Capital Fund Completed Projects</u>
- OCVM/SS Roof Project - $163,322.78
- Clackamas Hts. Decks - $126,688.72
- Scattered Sites Furnace Project - $86,500.00
- Asbestos Abatement Services - $50,000.00
- Asbestos Air Monitoring Services - $30,000.00
- Modernization of 9680 74th - $132,503.21
- HACC Wide Flooring - $250,000.00

<u>2020 Proposed Capital Fund Projects</u>
- On Demand Moving Contract - $25,000.00

- On Demand Cabinet Contract - $125,000.00
- Scattered Sites Fencing Project - $175,000.00
- On Demand Flatwork Project - $135,000.00
- Hillside Manor Elevator Upgrades - $700,000.00

Q: Where do the funds come from when a tenant moves?
A: General unit turnovers, the funds come from operations. For things like floors and cabinets, the funds come from Capital Grant through our on-demand contracts.

Q: Do we need to clean the unit if you will be demolishing it?
A: It is too early to answer that question and this is still a year out. There will be a level of cleaning expectation and that you don't leave personal property in your unit.

Josh discussed a breakdown of next year's proposed funding/budget:

- 1406 - operations 20% of grand total
- 1408 - management improvement software in HAB ($500.00)
- 1410 - is administration $122,559.40
- 1411 - audit $6,500
- 1430 – asbestos or architectural and engineering- $25,000
- 1450 – onsite improvements $15,000
- 1460 - PHA Wide Dwelling Improvements $744,779.10
- 1465 - Ranges & Refrigerators 0.00
- 1475 - Non-Dwelling Equipment $1,000.00
- 1495 - relocation cost $10,000

Q: Can you use a pod to relocate people?
A: Yes, depending on the circumstances.

1:20-1:30 Resident Services Overview

- The Board of County Commissioners (BCC) allocated funds to HACC for additional resident services staff to serve Public housing residents. The big news is we went from 1.5 resident services staff to 7:
    - Courtney VanSchoiack: primarily at Clackamas Heights but will soon have office hours at Oregon City View Manor. Her focus is connecting residents to basic needs, food, clothing, furniture etc. Support staff can really help people look at and determine goals, to go to school, employment options and career goals. She handles rent reporting and can connect residents to credit repair resources.
    - Emily Lilly: has taken over the community gardens.
    - Tiffany Kearney: peer support specialist, offering mental health and addiction support. She can meet a person where they are and help with any resources they may need, or if they just want to talk to. Hoping to set up group meetings, bingo etc. maybe just support group-fraud. Maybe a painting group, movie night, cooking, etc.
    - Amy Brinkley: provides administrative support, but is also trained as a peer support specialist. She can offer support for mental health and addiction through lived experiences.
    - Jemila Hart: focused on supporting new people as they enter PH and connect them to basic needs, food, clothing, furniture, etc. Jemila can help people determine goals around school, employment and career goals. She also administers the IDA program.
    - We also have a case manager from Social Services joining the team in the near future.

- The team is excited about community building actives to help residents engage with Resident Services and their neighbors.

1:30-1:40 Family Self Sufficiency (Section 8) Overview

FSS Program is a 5-year voluntary employment-based program

- The purpose is to provide resources and referrals that will help the participant become as self-sufficient as possible off of government assistance. To complete the program a participant needs full time employment based on their training, education & experience, complete all their goals on the Individual Training and Service Plan (which we work on during the FSS intake) and be off of welfare assistance for 12 consecutive months prior to the expiration of the contract (welfare assistance is TANF only). Escrow account begins accruing after you have an increase in earned income that causes your family rent to increase. For instance, if your rent was $100 & then your rent increases to $300 based on earned income, then you could **potentially** earn up $200 in monthly escrow (the system looks at a number of factors to accrue escrow, so it is not guaranteed). If you successfully graduate from FSS, then you earn the escrow and may choose how to spend it. Participants have graduated earlier than the 5-year limit. We can extend a contract for up to two years, but only for good cause.
- Michell has written Letters of Recommendation for participants, walked through budgets, it all depends on the client. Each participant has a different level of need in the program. Some prefer constant communication, some monthly and some quarterly.
- You are only allowed to use FSS one time.
- A resident is ineligible for FSS if they owe money to HACC. It must be paid off before they can apply.
- There are slots for PH residents and a preference will be given to the scattered sites.
- Some FSS clients concurrently have an IDA (homeownership, vehicle or education).

Q: How can I be the first on PH to be on this program?
A: a letter with information about the FSS program and PH waitlist is being included with the February rent statements. PH residents that do not get rent statements will have a separate letter sent out at the same time. The letter will provide Michell's contact information to request to be added to the waitlist. We will contact those on the waitlist when we begin to pull names from it.

1:40-1:45 Annual Plan Timeline

- The proposed policies are open for public comment from January 20, 2020 through March 5, 2020
- The Public Hearing is open to public on March 19, 2020 at the Public Services Building, on the 4th floor.
- Goes to board for final approval on April 2, 2020
- HACC submits the final Annual Plan to HUD by April 17, 2020
- If you have questions, comments, you can contact Elizabeth at 503-655-8279 or at emiller@clackamas.us

1:45-2pm Questions and Answers

Q: How are you going to go about phasing out scattered sites?
A: We haven't figured out the phasing yet, but we are looking at giving a preference to anyone in any of our Scattered Sites, who are interested and eligible to buy their home. We are also changing our payment standards so people can live in areas where they want, which applies to those families who receive a voucher if their PH Scattered Site unit is sold.

Comments on HACC Annual Plan

Received anonymously on February 20, 2020

On the proposed change in bedroom allocation: One bedroom for single head of household and another family member, regardless of sex/gender/ age / generation… Targets single adults. And I believe placed significant stress and upheaval on all parties involved for many reasons. To be forced to move to limited one bedroom which are not always cheaper than current units. If one bedroom is shared each person may have to get new furniture (twin beds) a big expense. If one bedroom is shared by an older person and a child, there is increased chance of illness. If one bedroom is shared by a parent, or grandparent and a teenager there will be a lack of privacy and emotional refuge. Sex/gender may make this even more difficult.

How could the teen have friends over? How could the adult have intimate adult visitors or just private time and space?

It was pointed out that one person could sleep in the living room, which means anyone coming to the house is in someone's bedroom at all times and there is no living room for family and friends to gather.

This feels to me like a step backwards from helping the vulnerable and disadvantaged feel more like regular normal families. I don't believe it will work for many families, and will cause problems for many.

On the subject of HUD getting rid of Public Housing- Is this a done deal? Is anyone fighting this change? Moving the Public Housing tenants to Section 8 Vouchers sounds like a big mistake that will lead to many people losing the supports they have now. Which keep the most difficult to house from becoming homeless. Closing Mental Hospital didn't help the mentally ill.

Date: 3/5/20
Subject: HACC Annual Plan Comments
To: Elizabeth Miller
From: Abe Moland, Health and Transportation Impact Planner, CCPHD

Page 8 of 80: ***HACC continues to apply for new rental assistance program funding and when awarded is required to have language explaining the populations served by each funding source. Adding new funding sources***

Comments:

Last sentence, 'Adding new funding sources', seems incomplete.

Page 19 of 80: ***Removed extra bedroom for single head of household with child(ren). This will make it 2 per bedroom regardless of age, sex, generation or any other consideration.***

Comments/Considerations:

As reader of the plan, it may be helpful a more detailed rationale for the changes outlined in Appendix A. This will be helpful in building larger community capacity on housing issues as well as make the document more accessible.

Considerations:
Crowding negatively impacts resident health, and particularly children and adolescents. Children in crowded homes are more likely to have problems coping with stress, poor parent interactions, negative mental health outcomes, increased risk of injury, elevated blood pressure, and more potential exposure to infectious disease[i]. Studies have also found connections between moving to smaller apartments and higher levels of stress in children[ii]. Assessing health across the lifespan using life course theory, the concept that key events and transitions in early life alter developmental trajectories, housing policy can influence the social trajectories of education, work, and family based on the conditions they create for early childhood[iii].

Possible policy perspectives/PPB considerations that may influence health outcomes include the age of children (infants vs teenagers), unit dimensions (square footage and design of bedroom and other potential sleeping areas), and quality of other housing elements (heating and cooling availability, indoor air quality, noise). In Clackamas County, 24.1% of households with children are single parent households[iv], roughly 93,806 families[v]. In reviewing this policy, it will be important to understand what proportion of these households are at income low enough to be affected by this change.

Eliminating a separate bedroom for single heads of households potentially creates preference for two-parent households, as couples with one child are still issued two bedroom units. Maintaining a separate bedroom for single heads of households helps facilitate health in all family types.

Questions:
- What is the rationale for removing the extra bedroom for single head of household?
- How many current HACC residents does this apply to? How many current Clackamas County residents would this apply to? How many applications on waiting lists does this apply to?
- Is this defensible with keeping single person families as eligible for one-bedroom designations?

Page 23 of 80 ***HACC is choosing to terminate an over-income family. This will allow HACC to continue serving low income families who need housing.***

Comments:
Households that experience forced moves are more likely to experience poor mental and physical health outcomes[vi]. Displacement from housing may also disrupt the employment or other circumstances that created the increase in income.

The move itself may result in incurred costs from relocation and set-up, increased transportation costs, and reduced time with family and engaging in other health promoting activities like exercise and sleep[vii].

A policy that triggers a forced move of a family based on income thresholds assumes a level of agency on the part of the household to no longer require assistance that may not be true. As families are required to report income changes within 7 days of a change, this leaves little time to conduct a formal housing search. For very low income households, this is likely to involve the use of personal safety nets and information networks (family and friends) and disallow consideration of neighborhood quality and opportunity[viii]. This also has the potential to disincentivize residents reporting new income for fear of forced transition.

Questions:

- How many over-income households are there currently within the HACC resident population?
- Is over-income family termination common practice in other jurisdictions?
- What are the policies and procedures associated with the termination process? How can this be done incorporating TIC-principles?
- Is this a barrier for low-income economic mobility?

Pg 36 of 80 – ***Attachment I C. PBV Resident Rights and Participation.***

Questions:

- Is this the handout that residents receive? Or is this the policy that dictates what is communicated in that handout? The Table of Contents identifies it as the Residents Right Handout, but it reads as a policy excerpt.

Pg 80 of 80 - ***HACC may convert its Public Housing properties to Rental Assistance Demonstration (RAD), as a result of the conversion, Capital Grant funding will be reduced by approximately $894,204/year. HACC may utilize the Replacement Housing Funds (RHF) in the amount of $147,421, to facilitate RAD conversion.***

Questions:

- What does the process look like for resident involvement in the RAD conversion process?

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[i] Cutts, D. B. et al. (2011). US Housing Insecurity and the Health of Very Young Children. *American Journal of Public Health*. 101(8), p. 1508-1514.
[ii] Singh, A. et al. (2019). Housing Disadvantage and Poor Mental Health: A Systematic Review. *American Journal of Preventive Medicine.* 57(2): p. 262-272.
[iii] Elder, G. H. (1998). The Life Course as Developmental Theory. *Child Development.* 69(1), p. 1-12.
[iv] U.S. Census Bureau, Single-parent Households with Children as a Percentage of Households with Children in Clackamas County, OR [S1101SPHOUSE041005], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/S1101SPHOUSE041005, March 2, 2020.
[v] U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates. Table S1101, retrieved March 2, 2020.
[vi] University of Wisconsin Population Health Institute. County Health Rankings Key Findings 2019.
[vii] Matsuoka, M., Lucky, J. (2017). Power, Place, and Public Health: A review of the Literature on the health impacts of displacement & Promise of Inclusive Community Development. Urban & Environmental Policy Institute.
[viii] Skobba K. Goetz, E. G.. (2013). Mobility Decisions of Very Low-Income Households. Cityscape: A journal of Policy Development and Research. 15(2) p. 155-178.

Health, Housing & Human Services
CLACKAMAS COUNTY

Richard Swift
Director

April 16, 2020

Housing Authority Board of Commissioners
Clackamas County

Members of the Board:

Approval of the Hillside Manor Guaranteed Maximum Price Amendment to the CMGC Contract with Walsh Construction

Purpose/Outcomes	Approval of the Hillside Manor Guaranteed Maximum Price Amendment to the CMGC Contract with Walsh Construction
Dollar Amount and Fiscal Impact	Total of Guaranteed Maximum Price (GMP) is $12,787,667
Funding Source	4% Low Income Housing Tax Credits (LIHTC), Housing Preservation Funds (OHCS), Perm Loan, HACC Seller Financing
Duration	April 2020 through the closing of the Hillside Manor
Previous Board Action	May 17, 2018 and October 24, 2019
Strategic Plan Alignment	1. Sustainable and affordable housing 2. Ensure safe, healthy and secure communities
Contact Person	Jill Smith, Executive Director, Housing Authority
Contract No.	N/A

BACKGROUND:
The Housing Authority of Clackamas County (HACC), a Division of the Health, Housing and Human Services Department, requests approval of the Guaranteed Maximum Price Amendment with Walsh Construction.

Hillside Manor is a 100 unit, 9 story residential building, originally constructed in 1970, serving low income households with incomes between 0 - 80% Area Median Income (AMI). The building has been owned and operated by the Housing Authority of Clackamas County (HACC) since original construction. In December of 2017, HACC received approval from the US Department of Housing and Urban Development (HUD) to convert Hillside Manor to a project based Section 8 subsidy under the Rental Assistance Demonstration (RAD) program for Public Housing properties. RAD enables HACC to pursue funding through the Low Income Housing Tax Credit (LIHTC) program to leverage debt and other fund sources and complete renovations on the building.

On May 17th, 2018, the HACC Board approved the Housing Authority's request to utilize a Construction Manager/General Contractor (CM/GC) contract in the rehabilitation of the Hillside Manor. Pursuant to this decision, an RFP process was initiated by County Procurement in November 2018. Walsh Construction was selected as the CM/GC for the Hillside Manor project on February 18, 2019. Under the guidelines of the A133 contract for CM/GC, negotiations were conducted collaboratively between Walsh Construction, County Counsel, and County Procurement. Early Work Amendments were authorized while the final Gross Maximum Price (GMP) construction contract was finalized so that Walsh could begin the process of building investigations and subcontractor negotiations.

In conjunction with County Procurement and County Counsel, the development team at HACC has worked collaboratively to arrive at a Guaranteed Maximum Price (GMP) contract amendment. This will establish the maximum price Walsh may charge to perform the rehabilitation work.

The rehabilitation of Hillside Manor is a vital part of the Housing Authority's development strategy in meeting its goal of creating 1,000 new units of affordable housing. Approval of Amendment 1 constitutes the County's binding commitment to complete this project and will allow the Hillside Manor Project to move forward on schedule.

RECOMMENDATION:
Staff recommends the approval of the Guaranteed Maximum Price Amendment with Walsh Construction. Staff further recommends authorizing Richard Swift, H3S Director to sign the Amendment on behalf of the Housing Authority Board.

Respectfully submitted,

Richard Swift, Director
Health, Housing & Human Services

Attachments:
1. GMP Amendment

FINAL

AIA® Document A133™ – 2009 Exhibit A

Guaranteed Maximum Price Amendment

for the following PROJECT:
(Name and address or location)

«Hillside Manor Renovation »
«2889 SE Hillside Street
Milwaukie, OR 97222 »

THE OWNER:
(Name, legal status and address)

«Housing Authority of Clackamas County »«»
«13930 South Gain Street
Oregon City, OR 97045 »

THE CONSTRUCTION MANAGER:
(Name, legal status and address)

«Walsh Construction Co./Oregon »«»
«2905 SW 1st Ave,
Portland, OR 97201»

ARTICLE A.1
§ A.1.1 Guaranteed Maximum Price
Pursuant to Section 2.2.6 of the Agreement, the Owner and Construction Manager hereby amend the Agreement to establish a Guaranteed Maximum Price. As agreed by the Owner and Construction Manager, the Guaranteed Maximum Price is an amount that the Contract Sum shall not exceed. The Contract Sum consists of the Construction Manager's Fee plus the Cost of the Work, as that term is defined in Article 6 of this Agreement.

§ A.1.1.1 The Contract Sum is guaranteed by the Construction Manager not to exceed « fourteen million seventy-six thousand two hundred nineteen dollars » ($«14,076,219.00»), subject to additions and deductions by Change Order as provided in the Contract Documents.

§ A.1.1.2 Itemized Statement of the Guaranteed Maximum Price. Provided below is an itemized statement of the Guaranteed Maximum Price organized by trade categories, allowances, contingencies, alternates, the Construction Manager's Fee, and other items that comprise the Guaranteed Maximum Price.
(Provide below or reference an attachment.)

«Refer to Exhibit A.1 – Schedule of Values»

§ A.1.1.3 The Guaranteed Maximum Price is based on the following alternates, if any, which are described in the Contract Documents and are hereby accepted by the Owner:
(State the numbers or other identification of accepted alternates. If the Contract Documents permit the Owner to accept other alternates subsequent to the execution of

ADDITIONS AND DELETIONS: The author of this document has added information needed for its completion. The author may also have revised the text of the original AIA standard form. An *Additions and Deletions Report* that notes added information as well as revisions to the standard form text is available from the author and should be reviewed.

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion

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this Amendment, attach a schedule of such other alternates showing the amount for each and the date when the amount expires.)

«Refer to Exhibit A.2 - Alternates, Allowances and Unit Pricing»

§ A.1.1.4 Allowances included in the Guaranteed Maximum Price, if any:
(Identify allowance and state exclusions, if any, from the allowance price.)

Item	Price ($0.00)
Refer to Exhibit A.2 - Alternates, Allowances and Unit Pricing	

§ A.1.1.5 Assumptions, if any, on which the Guaranteed Maximum Price is based:

«Refer to Exhibit A.3 - Construction Manager's Clarifications, Exclusions and Qualifications»

§ A.1.1.6 The Guaranteed Maximum Price is based upon the following Supplementary and other Conditions of the Contract:

Document	Title	Date	Pages
Not Applicable.			

§ A.1.1.7 The Guaranteed Maximum Price is based upon the following Specifications:
(Either list the Specifications here, or refer to an exhibit attached to this Agreement.)
«Refer to Exhibit A.4 - Enumeration of Drawings and Specifications»

Section	Title	Date	Pages

§ A.1.1.8 The Guaranteed Maximum Price is based upon the following Drawings:
(Either list the Drawings here, or refer to an exhibit attached to this Agreement.)
«Refer to Exhibit A.4 - Enumeration of Drawings and Specifications»

Number	Title	Date

§ A.1.1.9 The Guaranteed Maximum Price is based upon the following other documents and information:
(List any other documents or information here, or refer to an exhibit attached to this Agreement.)

«See Exhibit A.8 – Cost Matrix (Final), which the parties adopt in place of Exhibit I – Cost Matrix (Draft).

§ A.1.1.10 The Guaranteed Maximum Price includes an identified contingency amount of three hundred eight thousand two hundred fifty-five dollars ($308,255.00), for the Construction Manager's use to cover those costs considered to be Costs of the Work under Article 6 of AIA Document A133-2009 but that are not included in the schedule of values or in a Change Order (the "Construction Manager's Contingency"). The Construction Manager's Contingency is not available for or to be used for design changes, Owner-directed scope changes, concealed or unknown conditions (as defined in Section 3.7.4 of AIA Document A201-2017), Force Majeure Events (as defined in Section 8.3.1 of AIA Document A201-2017), Pandemic Impacts (as defined in Section A.1.1.13), or design errors or omissions beyond the reasonable inferences described in Section 2.2.2 of AIA Document A133-2009. The Construction Manager will document its use of the Construction Manager's Contingency and review its use with the Owner at mutually agreeable intervals.

§ A.1.1.11 The Guaranteed Maximum Price includes an identified contingency amount of one million two hundred eighty-eight thousand five hundred fifty-two dollars ($1,288,552.00), for the Owner's use for design changes, Owner-directed scope changes, concealed or unknown conditions (as defined in Section 3.7.4 of AIA Document A201-2017), Force Majeure Events (as defined in Section 8.3.1 of AIA Document A201-2017), Pandemic Impacts (as defined in Section A.1.1.13), Pandemic Impacts (as defined in Section A.1.1.13), or design errors or omissions beyond the reasonable inferences described in Section 2.2.2 of AIA Document A133-2009 (the "Owner's

Contingency"). The Construction Manager cannot utilize the Owner's Contingency without Owner's approval in an executed CIC, Change Order, or Construction Change Directive. The Construction Manager will document the use of the Owner's Contingency and review its use with the Owner at mutually agreeable intervals.

§ A.1.1.12 The Owner and Construction Manager agree that (i) the Guaranteed Maximum Price is calculated based on the market prices for building materials at the date this Guaranteed Maximum Price Amendment is executed ("Cost Baseline"), (ii) the pricing of building materials in the marketplace is volatile, and (iii) sudden building-material price increases may occur during the course of construction that the Construction Manager cannot control or avoid. The Construction Manager will be entitled to an equitable adjustment of the Guaranteed Maximum Price if the price of any building materials increase by more than 5% of the price of the materials that was used to calculate the Cost Baseline, but only if (a) the price increase occurs within 90 days of the date that this Guaranteed Maximum Price Amendment is executed, (b) the price increase was not caused by the fault of the Construction Manager, and (c) the Construction Manager's Contingency established in Section A.1.1.10 is insufficient to cover the price increase. But clauses (a) and (c) are inapplicable when the price increase is attributable to a Force Majeure Event (as defined in Section 8.3.1 of AIA Document A201-2017) or a Pandemic Impacts (as defined in Section A.1.1.13).

§ A.1.1.13 The Parties acknowledge that conditions arising from or related to the 2019-2020 novel coronavirus/COVID-19 pandemic, including without limitation existing and future working conditions, labor availability, supply-chain interruptions, material shortages, price escalations, site and personal safety issues, additional costs and time required for safe performance of the Work, orders and directions of public authorities, laws, statutes, ordinances, codes, rules, and regulations, arising from or relating to the pandemic (collectively, "Pandemic Impacts") have impacted and may continue to impact the Owner's ability to pursue and manage the Project and the Construction Manager's ability to perform the Work as originally contemplated in the Contract Documents and within the Contract Time. The Parties therefore agree to (i) proceed with the Work on the basis of mutual trust, good faith and fair dealing, (ii) execute this Guaranteed Maximum Price Amendment, and (iii) use commercially and economically practicable efforts to complete the Work of the Project. Notwithstanding any other provision in the Contract, the Parties agree that Pandemic Impacts will be resolved as follows:

.1 The Contract Time, Contract Sum, and Guaranteed Maximum Price will be equitably adjusted to the extent that the scope of Work, Costs of the Work, and Schedule are affected by Pandemic Impacts;
.2 Contractor will use the Change in Condition process defined in Section 7.5 of AIA Document A201-2017 for purposes of equitably adjusting the Contract Time and/or the Guaranteed Maximum Price;
.3 Notice of Claim under Article 15 will not be required unless and until the Owner and Construction Manager cannot agree upon the adjustment to the Contract Time and Guaranteed Maximum Price.

§ A.1.1.14 Construction Manager acknowledges that this Contract is subject to the limits of the Oregon Constitution and contingent upon appropriation of funds by the Board of Commissioners for the Housing Authority of Clackamas County. As such, if and when Owner's Contingency is exhausted, Owner must appropriate additional funds before it may approve any further changes or adjustments to the Work under Sections A.1.1.12 or A.1.1.13. Construction Manager will continue to perform the Work (but not the further changes or adjustments to the Work in question) while Owner attempts to appropriate additional funds. If the Owner is unable to appropriate additional funds in a timely manner, the parties will first negotiate, in good faith, to find a commercially reasonable alternatives prior to either party exercising its rights to terminate the Contract. Such alternatives may include, but are not limited to, deductive Change Orders, design changes, or other means to appropriately reduce the scope of the Work. Owner will direct Architect to prepare revisions to the Contract Documents that incorporate any such agreed-upon reductions to the scope of the Work. Nothing is this Section A.1.1.14 alters either party's right to terminate the Contract in accordance with Article 14 of AIA Document A201-2017.

ARTICLE A.2

§ A.2.1 The anticipated date of Substantial Completion established by this Amendment:

«Subject to adjustments of the Contract Time as provided in the Contract Documents, the Construction Manager shall achieve Substantial Completion of the entire Work not later than 452 calendar days from the date of commencement of the Work. »

§ A.2.2 Final Completion

§ A.2.2.1 Construction Manager shall achieve Final Completion of the Work within 30 calendar days from the date of Substantial Completion.

ARTICLE A.3

§ A.3.1 The following exhibits are incorporated into the Agreement as Contract Documents and are as fully a part of the Contract as if attached to the Agreement or repeated therein;

- **.1** Exhibit A.1 – Schedule of Values
- **.2** Exhibit A.2 - Alternates, Allowances and Unit Pricing
- **.3** Exhibit A.3 - Construction Manager's Clarifications, Exclusions and Qualifications
- **.4** Exhibit A.4 - Enumeration of Drawings and Specifications
- **.5** Exhibit A.5 - Wage Rates
- **.6** Exhibit A.6 – Construction Schedule
- **.7** Exhibit A.7 – Form of Lender Consent
- **.8** Exhibit A.8 – Cost Matrix (Final)

ARTICLE A.4 LIMITED ASBESTOS ABATEMENT

Article 10. 5, Asbestos, of the AIA Document A201-2017 is hereby deleted in its entirety and replaced with the following provisions governing Construction Manager's treatment of asbestos as part of the Work.

§ A.4.1 Scope. Owner and Construction Manager acknowledge that asbestos has been encountered at certain locations at the Project site for reasons the parties do not attribute to Construction Manager. Owner has obtained the services of PBS Engineering and Environmental Inc ("Environmental Consultant") to prescribe the means and methods to be used by Construction Manager and its Contractors and Subcontractors to remediate the asbestos, which are contained in Section 02 82 13 of the Specifications ("Remediation Plan"). Construction Manager will hire NetCompliance Environmental Services, LLC ("Remediation Subcontractor") to remediate the asbestos conditions in the locations identified in and as prescribed by the Remediation Plan.

§ A.4.1.1 Owner acknowledges and the parties agree (a) that Construction Manager is not a certified industrial hygienist or expert in the field of hazardous materials, (b) that Construction Manager does not guarantee or warrant the efficacy or results of the Remediation Plan, (c) unless Construction Manager negligently fails to follow the Remediation Plan, Construction Manager will not be responsible in any way if the Remediation Plan is unsuccessful in whole or part, and (d) that Construction Manager liability to Owner for the remediation of asbestos is expressly limited to direct damages arising out of Construction Manager's negligent failure to follow the Remediation Plan.

§ A.4.1.2 Construction Manager will not remediate (a) asbestos conditions at locations that are not identified in the Remediation Plan, or (b) any other hazardous materials discovered on the Project site, except as expressly required in the Contract Documents. Without limiting the foregoing, Construction Manager is not responsible in any way (a) to address any asbestos that exists in the buildings or on the Project site that is not discovered by Construction Manager while performing its Work ("Concealed Asbestos Conditions") or (b) unless directed specifically as set out in this Section, to address asbestos conditions that differ materially from those identified in the Remediation Plan ("Unforeseen Asbestos Conditions").

§ A.4.1.3 When Unforeseen Asbestos Conditions are encountered, if the Remediation Plan does not prescribe how Construction Manager is to address those Unforeseen Asbestos Conditions, Construction Manager will immediately stop Work in the affected area and report the circumstances to Owner. Upon receipt of Construction Manager's notice, Owner will cause Environmental Consultant to define the means and methods to be used by Construction Manager and its Contractors and Subcontractors to remediate the Unforeseen Asbestos Conditions. If Construction Manager, in its sole discretion, determines that it is not qualified to remediate the Unforeseen Asbestos Conditions, Owner will be responsible to contract with others to render the Unforeseen Asbestos Conditions harmless. Work in the affected area will resume upon agreement of Owner and Construction Manager after the area is deemed acceptable to proceed. By Change Order, the Contract Time shall be extended appropriately and the Contract Sum shall be increased in the amount of Construction Manager's reasonable additional costs of shut-down, delay and start-up.

§ A.4.2 Delays. If the Construction Manager is delayed in the commencement or progress of the remediation Work by an and act or order of an authority having jurisdiction, the Contract Time shall be extended appropriately and the

Contract Sum shall be increased in the amount of Construction Manager's reasonable additional costs of shut-down, delay and start-up, except to the extent that such act or order resulted directly from the Construction Manager's failure to follow the Remediation Plan.

§ A.4.3 Indemnification.

§ A.4.3.1 Owner Indemnity. To the fullest extent permitted by law, Owner will defend, indemnify, and hold harmless Construction Manager, its Contractor and Subcontractors, and their respective agents and employees for, from, and against claims, damages, losses, citations, and expenses, including but not limited to attorneys' fees, arising out of or resulting from (a) Concealed Asbestos Conditions, (b) Unforeseen Asbestos Conditions, and (c) remediation of the asbestos performed in accordance with the Remediation Plan, except to the extent that such claim, damage, loss, citation or expense is caused by the fault or negligence of the party seeking indemnity.

§ A.4.3.2 Remediation Subcontractor Indemnity. Contractor shall include the following indemnification provision in its Subcontract with the Remediation Subcontractor.

> "Subcontractor will defend, reimburse, and indemnify Contractor, Owner, any other person or entity that Contractor is required to indemnify under the Prime Contract, and their respective subsidiaries, related entities, shareholders, representatives, officers, directors, agents, and employees (collectively, the "Indemnified Parties") and hold them harmless to the same extent that Contractor is obligated to defend, reimburse, and indemnify Owner and hold it harmless in the Prime Contract. In addition, to the fullest extent allowed by law, Subcontractor agrees to defend, reimburse, and indemnify the Indemnified Parties and hold them harmless for, from, and against any and all claims, liens, actions, suits, orders, demands, losses, expenses, damages, fines, penalties, costs, injuries and liabilities of any kind(including without limitation reasonable expert-witness and attorney fees) arising out of or relating to the Subcontract or the Subcontract Work to the extent caused by or contributed to by Subcontractor, its Associated Parties (including those for whom they are responsible)for their (i)breach of or failure to perform any provision of the Subcontract,(ii) violation of any Laws, or (iii) negligence or fault. Subcontractor's obligations under this section apply without limitation to bodily injury to persons, damage to property (including without limitation the Subcontract Work and the Project), economic losses, and consequential damages.
>
> Notwithstanding anything to the contrary in the Subcontract, Subcontractor is not required to indemnify or insure the Indemnified Parties for, from, and against liability for damage arising out of death or bodily injury to persons or damage to property to the extent caused by the negligence or willful misconduct of the Indemnified Parties."

ARTICLE A.5 MODIFICATION OF INSURANCE PROVISIONS

The Owner and Construction Manager wish to amend the Contract and modify Exhibit B of the Agreement ("Exhibit B") to release the Construction Manager from the obligation to purchase and maintain property insurance, and obligate the Owner to purchase and maintain property insurance. Therefore; in consideration of mutual promises and benefits, the Parties agree as follows.

§ A.5.1 Paragraph A.2.3.1 of Exhibit B is deleted in its entirety and replaced with the following:

> **§ A.2.3.1** The Owner shall purchase and maintain, from an insurance company or insurance companies lawfully authorized to issue insurance in the jurisdiction where the Project is located, property insurance written on a builder's risk "all-risks" completed value or equivalent policy form and sufficient to cover the total value of the entire Project on a replacement cost basis. The Owner's property insurance coverage shall be no less than the amount of the initial Contract Sum, plus the value of subsequent Modifications and labor performed and materials or equipment supplied by others. The property insurance shall be maintained until Substantial Completion and thereafter as provided in Section A.2.3.1.3, unless otherwise provided in the Contract Documents or otherwise agreed in writing by the parties to this Agreement. This insurance shall (i) include the interests of mortgagees as loss payees, (ii) include the Owner, Construction Manager and Subcontractors of every tier as Named Insureds , (iii) not include any "As Their Interests May Appear", "ATIMA", or similar references (iv) shall allow for the waiver of recovery prior to loss, (v) shall not include restrictive endorsements or warranties such as fences or watchmen unless approved in writing by the Construction Manager, and (vi) shall allow for partial occupancy without notice.

§ A.5.2 Paragraph A.3.3.2.1 of Exhibit B is deleted in its entirety and replaced with the following:

[« »] **§ A.3.3.2.1** Intentionally Deleted.

ARTICLE A.6 MODIFICATION OF AIA DOCUMENT A201-2017, ARTICLE 10

The Owner and Construction Manager wish to amend the Contract as follows.

§ A.6.1. Paragraph 10.3.3 of AIA Document A201-2017 is deleted in its entirety and replaced with the following:

§ 10.3.3 To the fullest extent permitted by law, the Owner shall defend, reimburse, indemnify and hold harmless the Contractor, Subcontractors, Architect, Architect's consultants, and agents and employees of any of them from, for and against claims, damages, losses, expenses and penalties, including but not limited to attorneys' fees, arising out of or resulting from performance of the Work in the affected area if in fact the material or substance presents the risk of bodily injury or death as described in Section 10.3.1 and has not been rendered harmless, provided that such claim, damage, loss, expense or penalty is attributable to bodily injury, sickness, disease or death, or to injury to or destruction of tangible property (other than the Work itself), except to the extent that such damage, loss, expense, or penalty is due to the fault or negligence of the party seeking indemnity. This Section 10.3.3 does not apply to claims arising from or related to asbestos. Claims arising from or related to asbestos shall be resolved exclusively pursuant to the terms and conditions of AIA Document 201, Section 10.5, Asbestos, as amended by this Guaranteed Maximum Price Amendment.

ARTICLE A.7 MODIFICATION OF AIA DOCUMENT A201-2017, ARTICLE 14

The Owner and Construction Manager wish to amend the Contract as follows.

§ A.7.1. Paragraph 14.1.3 of AIA Document A201-2017 is deleted in its entirety and replaced with the following:

§ 14.1.3 If one of the reasons described in Section 14.1.1 or 14.1.2 exists, the Contractor may, upon seven days' notice to the Owner and Architect, terminate the Contract. In case of such termination by Contractor, the Owner shall pay the Contractor for Work properly executed (including Contractor's Fee on such Work); costs incurred by reason of the termination, including costs attributable to termination of Subcontracts; and a termination fee equal to 320 hours of the wages or salaries, at the rates in A.5 - Wage Rates, of each of Contractor's supervisory and administrative personnel who were assigned to the Project at the date of termination. The Parties agree that the termination fee pursuant to this Section 14.1.3 will not exceed $112,000.00 USD.

§ A.7.2. Paragraph 14.4.3 of AIA Document A201-2017 is deleted in its entirety and replaced with the following:

§ 14.4.3 In case of such termination for the Owner's convenience, the Owner shall pay the Contractor for Work properly executed (including Contractor's Fee on such Work); costs incurred by reason of the termination, including costs attributable to termination of Subcontracts; and a termination fee equal to 320 hours of the wages or salaries, at the rates in A.5 - Wage Rates, of each of Contractor's supervisory and administrative personnel who were assigned to the Project at the date of termination. The Parties agree that the termination fee calculated pursuant to this Section 14.4.3 will not exceed $112,000.00 USD.

Except as specifically amended in this Amendment, all other terms and conditions of the Contract remain in full force and effect.

OWNER *(Signature)*	**CONSTRUCTION MANAGER** *(Signature)*
«Insert Owner Representative Name»«, Title»	«Ryan Wilde»«, General Manager»
(Printed name and title)	*(Printed name and title)*

Exhibit A.1 Schedule of Values

Est. No: 5 ***Date:*** 3/30/2020

Div #	*Division*	*Description of changes*	*Amount*	*Total*
1000	**General Requirements**			**1,072,783**
1000	General Requirements	Floor by Floor (2 floors at a time) - completion 8/9/2021	1,072,783	
2000	**Site Work**			**2,078,199**
2100	Site Preparation & Demolition	Unit, corridor, office and common area demo. Demo and prep for interior/ Exterior micro piles.	514,952	
2108	Abatement	Abatement of asbestos flooring and ceiling in unit bathrooms, overspray in unit walls, duct tape allowance, flooring abatement in common area, and ceiling abatement of units on 2nd floor, 9th floor, 8th floor.	871,623	
2200	Excavation	Temp road for Micro piles, laydown area, site prep for new curbs/ hardscapes, and disposal of spoils for micro pile	109,050	
2300	Retaining/Shoring/Piling Systems	Mirco piles.	435,935	
2500	Roads & Walks	Seal coat over all asphalt, striping, misc asphalt for micro pile, new islands at upper parking lot, hardscapes.	112,535	
2600	Water Distribution		-	
2700	Drainage Systems	Electrical Trenching , cleaning site drains. No Storm figured	13,850	
2800	Site Improvements	Handrail, (2) benches	9,055	
2900	Landscaping / Irrigation	Landscaping	11,200	
3000	**Concrete**			**812,842**
3200	Reinforcement	Reinforcing supply/install for micropile caps, columns, and concrete shearwalls.	268,558	
3300	Cast-in-Place Concrete	Seismic upgrades- concrete walls, column wrap, pile caps.	520,204	
3400	Precast Concrete		-	
3500	Concrete Topping Slabs		-	
3600	Grouting	Repair of concrete spalling along parapet to roof connection per RFI 18.	24,080	
3700	Sandblasting		-	
3800	Housekeeping Pads - Electrical/Mechanical		-	
3900	Miscellaneous		-	
4000	**Masonry**			**-**
5000	**Metals**			**177,872**
5100	Structural Steel	HSS attachments to 2nd Floor slab, plate steel reinforcing at existing concrete walls along grid F and grid 6, included grout. Operable Partition Beam also included.	146,613	
5200	Metal Joist		-	
5300	Metal Deck		-	
5500	Metal Fabrications	Railing attachments to existing concrete curbs (common area decks). Counter top brackets. Modification of roof stairs.	31,259	
5700	Ornamental Iron		-	
5800	Expansion Control		-	
6000	**Wood & Plastics**			**422,240**
6100	Rough Carpentry	Furring at walls for steel plate.	11,770	
6200	Finish Carpentry Labor	Doors, Hardware, Mailboxes, wood sill install at ground floor storefront	163,000	
6400	Architectural Woodwork	Cabinet replacement at 25 units, new pantry cabinet at 95 units, cabinet hardware in all units, and common area casework.	247,470	
6700	Siding & Trim		-	
6800	Decks & Railings		-	
6900	Miscellaneous Carpentry		-	
7000	**Thermal & Moisture Protection**			**132,331**
7100	Envelope Coordination	Alek - QA/QC Management - 88 hours for BEC Prep/Meeting/follow-up, and construction site visits and reports; Skin Doctor - 4 weeks. Building wrap of exterior storefront openings.	19,942	
7200	Insulation	Fiberglass bat insulation at new/walls opened during work, ground floor insulation	27,988	
7240	EIFS---Exterior Insulation & Finish System		-	
7250	Firecaulking	Misc. fire-caulking to bring existing penetrations up to code.	5,000	
7300	Roofing Shingles		-	
7400	Metal Roofing & Siding		-	
7500	Membrane Roofing	Strip in of new overflow drains, roof tie-off anchors, and aluminum coating of entire roof. New 30 year warranty to be provided at completion of project.	58,712	
7570	Traffic Coating		-	
7600	Flashing & Sheet Metal	Pile cap flashing. No work at roof or parapet.	11,875	

Exhibit A.1 Schedule of Values

Est. No: 5 ***Date:*** 3/30/2020

Div #	*Division*	*Description of changes*	*Amount*	*Total*
7800	Skylights		-	
7900	Joint Sealants	Caulking at sides of exterior micro piles.	8,814	
8000	**Doors & Windows**			**256,824**
8100	Metal Doors & Frames	Timely / HM Frames and Doors	52,113	
8200	Wood Doors	New Unit Entry Doors (18 units). Common Area doors	41,067	
8300	Special Doors		-	
8400	Storefront Assemblies	Ground floor and 2nd floor storefront frames, door, hardware, glazing	70,658	
8500	Windows		-	
8700	Hardware	New Unit Entry Door Hardware (100 units), All Common Area doors.	82,934	
8800	Glass & Glazing	Interior door relites, mirrors at common areas	10,052	
9000	**Finishes**			**913,686**
9100	Metal Framing Systems		-	
9200	Plaster		-	
9250	Gypsum Drywall	Metal framing and dyrwall	403,343	
9300	Tile	Included in flooring (see below)	-	
9400	Wood Flooring		-	
9450	Stone		-	
9500	Acoustical Ceilings	2nd floor office, ground floor and corridor ceilings floors 2-9.	76,267	
9600	Resilient Flooring	SV at unit bathrooms and LVT at common areas, New LVT flooring at (5) units	99,639	
9700	Carpet	Carpet tile, rubber base, and walk-off mat	90,662	
9720	Special Flooring	Sealed concrete included in flooring above	-	
9800	Special Coatings		-	
9900	Painting	Unit kitchen and bathroom paint, corridors on floors 2-9, full unit paint of units on 2nd floor, 9th, floor, 8th floor, all reprogrammed areas, elastomeric at exterior floors G, 2, and painting of exterior duct - all floors.	243,774	
10000	**Specialties**			**113,114**
10100	Display Boards		-	
10150	Compartments		-	
10200	Louvers & Vents		-	
10260	Corner Guards	Common Area	2,508	
10270	Access Flooring		-	
10290	Pest Control		-	
10300	Fireplaces		-	
10350	Flagpoles		-	
10400	Identifying Devices	Interior building signage	19,155	
10500	Lockers		-	
10520	Fire Protective Devices	Knox Box and FEC/ FE	5,973	
10530	Protective Covers		-	
10550	Postal Specialties	Electronic Parcel Box and Mailboxes	24,300	
10600	Partitions	Operable partition in the community room	13,105	
10750	Telephone Specialties		-	
10800	Toilet & Bath Accessories	New bathroom accessories- 95 units. Includes a vanity mirror.	48,073	
10900	Closet Specialties		-	
10990	Other Miscellaneous Specialties		-	
11000	**Equipment**			**23,763**
11010	Window Washing Equipment		-	
11060	Theater Equipment		-	
11110	Commercial Laundry Equipment		-	
11130	Audio Visual Equipment		-	
11160	Loading Dock Equipment		-	
11170	Waste Handling Equipment		-	
11400	Food Service Equipment		-	
11450	Residential Appliances	New community room, 2 break room appliances, install of residential appliances.	23,763	
12000	**Furnishings**			**122,506**
12300	Countertops	Quartz countertops at all unit kitchens and common areas	117,538	
12500	Window Treatment	New roller shades at 9 common area windows.	4,968	
12600	Entrance Mats		-	

Exhibit A.1 Schedule of Values

Est. No: 5 ***Date:*** 3/30/2020

Div #	*Division*	*Description of changes*	*Amount*	*Total*
13000	**Special Construction**			**-**
14000	**Conveying Systems**			**20,955**
14100	Dumbwaiters		-	
14200	Elevators	Elevator modernization and cab interior upgrades - in early amendment. Fire alarm, low voltage, electrical upgrades required to meet code.	20,955	
14300	Escalators		-	
14400	Lifts		-	
14500	Material Handling Systems		-	
15000	**Mechanical**			**2,493,410**
15200	Mechanical Insulation		-	
15300	Fire Protection	Modification of heads at corridors and reprogrammed areas.	137,831	
15400	Plumbing	Domestic water system replacement, horz waste replacement at units and ground floor (no vertical mains), ejector pump, and gate valve. New fixtures at units (except bath vanity sink).	1,610,173	
15500	HVAC	Heating and cooling systems for re-programmed areas, new ductwork for supply to corridors and units (as needed), and new bath fans at all units.	745,405	
15900	Controls		-	
16000	**Electrical**			**1,005,473**
16200	Underground Distribution		-	
16400	Service & Building Wiring	Bath fan wiring- 100 units, GFCI at kitchens and bathrooms- 95 units, electrical modifications for reprogramming and seismic upgrades including power to new HVAC systems.	352,889	
16500	Light Fixtures	New lighting in corridors floors 2-9, ground floor, 2nd floor common area, and in-unit bath/kitchen lighting. Also includes (6) new parking pole lights. "Better" light fixtures included.	312,879	
16700	Systems	Fire Alarm, low voltage, and door access control. Includes bedroom smoke detector tied into fire alarm system	338,452	
16800	Temporary Electrical	Connection at GC trailer/laydown yard and for micropile work. Power by HACC.	1,253	
17000	**Other**			**1,488,420**
	Subcontractor Bonding		-	
	Hoisting - Crane		-	
	Hoisting - Man/Material Hoist	June through December	325,991	
	Conformed Set Allowance- Davis Bacon Changes		25,000	
	Temporary Protection & Temporary Walls	Temporary protection of unit floors, common areas, corridors, and office areas as needed. Includes construction signage.	160,813	
	Parking	Figured on-site or in neighboring community.	-	
	Clean-up, Drop Boxes, Equipment, Survey	General Jobsite Items - Equipment, layout, survey, general clean-up, drop boxes, safety supplies.	590,253	
	Final Cleaning	Final cleaning of units, corridors, common spaces.	53,658	
	Safety Plan	Safety Director's site visits once per week and monthly jobsite safety audits, in addition to pre-con meetings, and site specific safety manual. Figures 202 hours.	15,576	
	Pest Control Supplies	Cedarcide, tyvek suits, and necessary training for employees to safely work in occupied building.	8,875	
	Permits & Fees			
	Sidewalk Rental			
	Street Rental / Parking Meter Rental Fees			
	Sanitary Sewer Connection Fee			
	Storm Sewer Connection Fee/Charges			
	Water Meter/Connection Fee/Vault			
	Electrical Connection Fee			
	Off-Site Improvements			
	Certified Survey			
	Cost Certification			
	Adjustments			
	Cost Indexing		-	
	Contingency	3% construction contingency	308,255	

Exhibit A.1 Schedule of Values

Est. No: 5 ***Date:*** 3/30/2020

Div #	*Division*			*Description of changes*		*Amount*	*Total*
				SUB-TOTAL			**11,134,418**
	Overhead & Profit					3.75%	417,541
				SUB-TOTAL			**11,551,958**
	Liability Insurance					1.96%	226,418
	Builders Risk Insurance			By HACC with Waiver of Subrogation			
	B & O Tax (see below)					0.00%	-
				SUB-TOTAL			**11,778,377**
	Performance Bond	First	2,500,000		2,500,000	0.695%	17,496
		Next	2,500,000		2,500,000	0.610%	15,343
		Next	2,500,000		2,500,000	0.580%	14,584
		Next	12,500,000		4,278,377	0.565%	24,309
		Over	20,000,000		-	0.535%	-
				SUB-TOTAL			**11,850,109**
	State Sales Tax					0.00%	-
				SUB-TOTAL			**$ 11,850,109**
	Oregon Gross Receipts Tax					0.38%	45,030
				TOTAL			$ 11,895,139
					Cost per SF		162
	Preconstruction Costs			Preconstruction			110,000
				MEP / Micro Pile Precon & Permits (Amendment #1)			245,534
				Early Procurement- Elevator (Amendment #1)			536,993
				TOTAL precon/early procurement			892,527
	Walsh Contract Total						12,787,667
					Cost per SF		174

See Attached "Estimate Exclusions, Clarifications & Allowances"

END

Project: ***Hillside Manor***

Exhibit A.2 - Alternates, Allowances and Unit Prices

3.30.2020

	ALTERNATES SHEET			
	TOTAL	**$**	**2,720,173**	***Priority*** High
	ABATEMENT OF CEILINGS ONLY TOTAL	**$**	**645,123**	Med
				Low
				End
0A	**COVID Schedule Option : Aggressive Road** : 18 Unit sequence on East Side, 21 Unit Sequence on West Side - Project Completion: 10/11/2021	**$**	**220,000**	
0M	**COVID Schedule Option : Middle Road**: 12 Unit Sequence on East Side, 21 Unit sequence on West Side -Project Completion: 1/07/2022	**$**	**490,000**	
0C	**COVID Schedule Option : Conservative Road**: 12 Unit Sequence on East side, 14 Unit Sequence on West Side- Project Completion: 3/18/2022	**$**	**715,000**	
1	**ALT- Additional Security Camera's (Existing Head-in Equipment and Camera's to remain)**	**$**	**64,119**	High
2	**ALT - Unit Lighting Upgrades (Except Kitchen and Bath)**	**$**	**108,563**	Low
3	**ALT - New Unit Bathroom Wall Hung Lav (new faucet in base GMP)**	**$**	**6,963**	Low
4	**ALT - Unit Window Coverings - Mini Blinds- Rejected**	**$**	**-**	
5	**ALT - Unit Window Coverings - Roller Shades**	**$**	**51,682**	Low
6	**ALT - Paint Exterior Floors 3-9 with Elastomeric Paint**	**$**	**79,011**	Med
7	**ALT - Upgrade Unit Baseboard Heaters to Cove Heaters near Ceiling- Rejected**	**$**	**-**	
8	**ALT - Community Garden Refresh and Expansion - Allowance**	**$**	**105,865**	End
9	**ALT - NewTraffic Coating at Exterior Decks over Existing coating**	**$**	**104,525**	Med
10	**ALT - Fire Sprinkler Upgrades - Cages**	**$**	**10,208**	Med
11	**ALT - Abate Ceiling and Paint Entire Unit (Floor 9) - (13 units) - Included in GMP**	**$**	**-**	
12	**ALT - Abate Ceiling and Paint Entire Unit Floor 8 - (12 units) - Included in GMP**	**$**	**-**	
13	**ALT - Abate Ceiling and Paint Entire Unit - Floor 7 - 10 Units**	**$**	**120,307**	High
14	**ALT - Abate Ceiling and Paint Entire Unit - Floor 6 - 13 Units**	**$**	**146,459**	High
15	**ALT - Abate Ceiling and Paint Entire Unit Floor 5 - 12 Units**	**$**	**137,742**	High
16	**ALT - Abate Ceiling and Paint Entire Unit Floor 4 - 10 Units**	**$**	**120,307**	High
17	**ALT - Abate Ceiling and Paint Entire Unit Floor 3 - 10 Units**	**$**	**120,307**	High
18	**ALT - Flooring Abatement and LVT Replacement (Units with Asbestos Ceiling)- Per Unit Cost**	**$**	**7,302**	

18B	ALT - Flooring Abatement and LVT Replacement (Units without Asbestos Ceiling)- Per Unit Cost	$ 10,357	
19	ALT - Unit Interior Doors - Per Unit Cost (Existing Frames and hardware remain)	$ 2,238	Low
20	ALT - Corridor Handrail - Sand and re-stain	$ 27,660	Low
21	ALT - Replace Existing Kitchen Rooftop fans with new	$ 27,118	Med
22	ALT - Add Additional Showers	$ 2,235	Low
23	ALT - Shelter - Assume it bolts to existing sidewalk	$ 16,978	High
24	ALT - Coiling Door at Service Entry- Rejected	$ -	
25	Operable Partition - Included in Base GMP	$ -	
26	ALT - Provide Card Readers at all Stair Doors- Rejected	$ -	
27	ALT - Irrigation Repair - Allowance	$ 10,745	End
28	ALT - Sidewalk Replacement at Main Entrance	$ 13,538	End
29	ALT - Replace Additional Unit Entry Doors (Per Door Cost)	$ 942	Low

Allowances:

All Allowances below include cost of Labor, Material, Overhead, Equipment, Subcontractor, and Supervision

- Overexcavation / Shoring for soil sluffing off- Allowance $ 50,000
- Interior Elevator Finish - Allowance $ 23,400 per car
- Conformed Set / Davis Bacon Final Wage Rate - Allowance $ 25,000
- Asbestos Abatement- Allowance $ 710,447
- Asbestos Duct Felt Tape (no included above) - Allowance $ 50,000

Exhibit A.3 Construction Manager's Clarifications, Exclusions and Qualifications

Project: **Hillside Manor**	Estimate #: GMP Estimate	Date: 3/30/2020

Clarifications:

General

- GMP includes the higher of Commercial Boli prevailing wages as of 7.1.17 with the October 1, 2017 Amendment and Davis Bacon Building as of 8.30.19 for each classification
- Electrical and water utility bills assumed to be paid by HACC
- Jobsite office and lay down yard assumed to be in the lower parking lot and adjacent field.
- Parking for construction workers assumed to be in neighborhood surrounding site
- Flush toilet for workers (OSHA required) assumed to be existing toilet in the building or community building. Porta potty's provided on-site for workers.
- Budget assumes all resident or on-site staff possessions will be removed from work areas prior to commencement of work
- Punch/turnover to completed as construction in units are finished per floor
- All work assumed to be completed during normal working hours (8am-5pm). No OT is included
- Project assumed to start May 18, 2020, 67 week construction schedule
- GMP includes use of man material hoist during elevator modernization at beginning of project from June through Mid- December
- Budget and schedule assumes construction on floors 2-9 is completed two floors at a time, starting with floors 9 and 8 and progressing down to level 2.
- Budget and schedule assume refresh of vacant units that will be used for temporary housing will be refreshed by property management as a typical turn and are excluded
- Assumes building not considered high-rise by AHJ
- **Budget based on the following documents :**
  - Architectural Spec - SEA - 11.8.19 (419 pages)
  - Architectural Bid / Permit drawings - SEA - 11.8.19 (131 pages)
  - Addendum 1 - 12.6.19
  - RFI 1-10, 12-18, 20
  - Revised RCP's 1.15.2020 provided as part of Lighting VE

Division 01000

- GMP figures pay-apps include sub pay-apps and lien releases for contracts over $250K only.

Division 02000

- GMP includes Abatement scope of work as Allowance - See Allowances.
  - Abatement allowance based on PBS Survey Report dated July 2019 and scope outlined below:
    - Abatement allowance includes removal of popcorn overspray in walls and on piping to complete the plumbing work at the kitchen and bathroom.
    - Abatement allowance includes flooring abatement in (5) units that are already having the ceiling abated.
    - Abatement Allowance includes ceiling abatement and flooring abatement in all unit bathrooms
    - Abatement Allowance includes ceiling abatement in units that tested positive for asbestos on floors 2, 9, and 8.
    - Abatement Allowance includes abatement of ground floor flooring.
- A separate allowance is provided for the removal of the duct felt tape. See allowances.
- Plant 12 ea new arborvitae along train tracks
- GMP includes an allowance for sluffing/caving in soil at sub-grade footings. See Allowances.

Division 03000

- GMP includes design build micro piles

Division 04000

Division 05000

Division 06000

- Cabinets- all plywood construction with veneer

Division 07000

- Cell tower equipment to be relocated by others as needed for completion of aluminum coating on roof
- AT&T stated some equipment is obselete, and the platform footprint can decrease. Since roof is not being replaced, it is figured that any equipment AT&T removes is done by others and that the curb on the roof does not get altered.
- Revised Roofing Scope: Per Pending RFI 019
  1. Clean existing roof surface and apply aluminum roof coating Garland-Brite over the entire surface
  2. Install mineral surface torchdown reinforcing over seperation ridge at approx grid line 5.
  3. Install 2-ply mineral surface torchdown membrane at (4) new overfloor drains
  4. Install 2-ply mineral surface torchdown membrane at (9) new fall protection anchors bases, with PMMA at vertical anchors points
  5. Install PMMA at saddle flashing to the penthouse and roof transition at the staiway access door
  6. Install modiified mineral surface walk pads as shown on roof plan A2.31, prior to aluminum coating being applied.
  7. Provide 30 year manufacturer's warranty at completion of the project

8. Install new drain at approx 6.1/B.5 to mitigate ponding to the north of the AT&T equipment curb

Division 08000

- 1/4" tempered glass included at all interior relites and doors. No fire rated glass included.
- Wood doors are plain sliced white birch. Prefinished.
- New unit entry door hardware - 100 units
- Kawneer Storefront included, standard finish line.
- All openings on the ground floor and second floor office figured as non-rated, except Opening 120A which is 45 minutes
- Stair door hardware - new closures at all stair doors and central balconies. All other hardware to remain.
- Hardware is based on RFI 3 schedule, and hardware coordination meeting with SEA, HACC, and HDC which updated line to schlage.
- Operable partition (Moderco 842), steel beam, and drywall soffit are included

Division 09000

- Assume new soffit only in unit bathrooms per RFI 2
- Prime and paint only figured at ceiling that get abated. No texture figured at ceilings.
- Units below accessible shower to have larger soffit with can light per RFI 2
- New kitchen soffits included in X01, X12, and X13 stacks only
- LVT flooring figured at (5) units that get new flooring.
- Sherwin Williams Paint included. Promar 200 zero VOC for interior paint and the ProBlock Primer to cover existing grease and smoke on existing walls.
- Package Locker Module from Parcel Pending included. Montly service fee to be paid by owner or tenants.

Division 10000

- Existing mailboxes to be temporarily relocated during Ground floor construction by Walsh. Mailbox to be located adjacent to main entrance in a temporary shed.
- Interior signage includes ADA compliant unit signs, evacuation maps and directional signs at each elevator lobby, stairwell landing signs, public restroom signs, exit signs at doors, stair/floor signs, code vinyl signs for fire alarm, sprinkler, electrical, (46) room ID signs for common areas.
- Signage figured as single vinyl sign color with contrasting lettering color. One color combination for all interior signs figured. Mounted with 3m VHB tape.

Division 11000

- Includes install of Unit applicances, recycling of existing and supply of new by owner
- Includes supply/ install of anti-tip devices at all ranges

Division 12000

- Countertops are figured as 3 cm MSI "Group 1" Slab Quartz throughtout units and common areas.
- Window Shades included are from manufacturer: WT Shades - Heliarise, H200 Manual Roller Shades.

Division 13000

Division 14000

- Elevator modernization on both cabs to be Elevonic GEN2 Gearless systems
- Elevator modernization and interior cab refresh to be completed concurrent of other work.
- Interior cab finishes carried as an allowance. See Allowances below.

Division 15000

- All vertical waste piping to remain in place
- New elevator sump pump
- No work in 5 unit ADA bathrooms except connections for plumbing scope noted above as needed
- Aquatic 4-piece tub shower in 80 units
- Fiberglass base and 3-sided walls for 15 low profile showers (none to be installed on floors 4, 6, 8 due to sequencing)
- New floor-mount, rear outlet ADA toilets in 95 units
- New lav faucets at reset existing sinks
- ADA compliant grab bars to be installed at factory on tubs and shower surrounds.

Division 16000

- New unit bathroom lights at vanity only (except at units below 15 ea new roll-in showers can lights)
- Replacing exterior wall mounted lights with LED lighting
- Lighting based on revised lighting plan 1.15.2020 after VE effort.

Exhibit A.3 Construction Manager's Clarifications, Exclusions and Qualifications

Project: **Hillside Manor**	Estimate #: GMP Estimate	Date: 3/30/2020

Division 17000

- Existing Head-in equipment is moved by HACC IT staff. Walsh to assist in looping existing wire over to new location.
- HACC to coordinate with providers (phone, data, cable, security) on which wires are operational and label wires to its final destination and which can be cut and removed. Walsh to remove any obsolete wiring in ceilings opened during construction.
- Localized prop alarms included at all corridor to stair doors.
- New wire from all 2nd floor camera's to ground floor IT rack included.
- $15,000 budget for NVR storage of camera footage included.

Project Specific Exclusions:

General

- Any utility infrastructure work outside of building, except wiring to new lighting.
- Security cameras, (except as noted above) - see Alternate list
- Installation of furniture
- Builders Risk and Property Insurance. HACC policy must include waiver of subrogation, and list Walsh and Subcontractors as additionally insured.

Division 01000

- Design/engineering of acoustical systems and details
- Design/engineering of cold formed metal framing and metal furring assemblies, or shop drawings for same
- Dedicated accounting support

Division 02000

- Thrermoplastic Striping
- New or re-work of existing storm piping
- Installed dewatering. Budget assumes water table is low enough that dewatering will not be required
- Structural fill for micro pile (assumes native cut can be re-used)
- Survey- This estimate excludes checking or re-establishing existing property corners. This estimate includes all layout inside of the property corners
- Repair/ replace irrigation. See Alternates

Division 03000

Division 05000

Division 06000

- Removal/re-installation of or new handrails in common corridors (see ALT list)
- FRP at trash or laundry rooms. FRP only included at janitor's sink in maintenance room.
- Access doors in hard lids (assume all isolation valve access through ACT)
- FSC wood
- Urea formaldehyde free (UFF) materials

Division 07000

- Roof Abatement
- Roof removal and replacement
- Sheet Metal Flashing at roof and parapets

Division 08000

- Grouting of hollow metal frames
- Interior storefront UNO
- Window film
- Coiling overhead (Wayne Dalton Model 600 HC) door on Ground Floor - Deleted from Project

Division 09000

- Painting of exposed ductwork, pipes, wire, conduit, etc. unless exposed in units getting full paint or as noted on exterior as receiving paint
- Unit Flooring (except as noted above). (See Alt). Only bathroom flooring is included.

Division 10000

Exhibit A.3 Construction Manager's Clarifications, Exclusions and Qualifications

Project: **Hillside Manor**	Estimate #: GMP Estimate	Date: 3/30/2020

- Folding shower benches, as shown in ADA units on A6.32.
- Exterior Building name or address signage. Monument sign.
- APCO message clip on interior signs.

Division 11000

- Trash compactor

Division 12000

- Furnishings, Fixtures & Equipment (FF&E)

Division 13000

Division 14000

Division 15000

- Dryer booster fans
- Fire/smoke dampers at unit bathroom/ kitchen exhaust or unit supply air
- Stairwell and elevator pressurization
- Insulation on pex piping within units
- Any addition of or work on existing utility meters

Division 16000

- Utility Company Connection Fees and Offsite Infrastructure
- Addition/relocation/removal of any security cameras or associated wiring (see ALT list)

Division 17000

- Subcontractor bonding.
- Security and/or fire watch guards
- Resident relocation costs
- Relocation of gym, laundry, and property management office. Mailbox relocation costs included.
- Cleaning of hotel units between each turn

Standard Exclusions:

- Plan Check Fee
- Building Permit Fees
- Master Use Permits & Fees
- Assessments
- All-Risk Insurance
- Mitigation Fees & Expenses
- Impact Fees
- Record drawings on CAD.
- Pest Treatment and Inspections
- Project Photographs
- Code interpretation--this is a design professional's r
- Smoke control analysis/modeling/testing
- Window testing--WCC will coordinate with owner's 3rd party rep
- Testing, engineering, and special inspection - WCC will coodinate
- Cost Certification
- Rock Excavation
- Underground Obstructions and/or Conditions that Hinder Construction
- Any Warranty Beyond Manufacturers Standard Published Warranty
- Subcontractor/Suppliers Individual Lien Releases for subs under $250K.
- Printing Cost(s) for Architects Plans & Specifications
- Mold remediation
- Radon gas remediation
- DAS system

Allowances:

All Allowances below include cost of Labor, Material, Overhead, Equipment, Subcontractor, and Supervision

Overexcavation / Shoring for soil sluffing off- Allowance	$ 50,000	
Interior Elevator Finish - Allowance	$ 23,400	per Car
Conformed Set Allowance	$ 25,000	
Asbestos Abatement	$ 710,447	
Asbestos Duct Felt Tape - Allowance	$ 50,000	

Exhibit A.4

Index of Contract Documents

Dwg. No.	Drawing Name	Date	Add. #1	Revised
General by Scott Edwards Architecture, LLP				
	Cover Sheet			
G0.01	General Project Information	11/08/19	12/06/19	
G0.02	Architectural General Notes	11/08/19		
G0.03	General Diagrams	11/08/19		
G0.04	Assemblies	11/08/19	12/06/19	
G0.12	Existing Photos - Units	11/08/19		
G0.13	Existing Photos - Second Floor Common Spaces	11/08/19		
G0.14	Existing Photos - First Floor Common Spaces	11/08/19		
G1.01	Code Summary	11/08/19	12/06/19	
G2.21	Code Plan - Levels 1 & 2	11/08/19	12/06/19	
G2.22	Code Plan - Levels 3 & 4-9	11/08/19	12/06/19	
Survey by Westlake Consultants, Inc.				
1 of 7	A.L.T.A / N.S.P.S. Land Title Survey (For Information Only)	07/03/18		07/25/18
6 of 7	A.L.T.A / N.S.P.S. Land Title Survey (For Information Only)	07/03/18		07/25/18
Architectural by Scott Edwards Architecture, LLP				
AD1.01	Demo Site Plan	11/08/19	12/06/19	
AD2.01	Level 1 - Demo Plan	11/08/19	12/06/19	
AD2.02	Level 2 - Demo Plan	11/08/19		
AD2.03	Level 3 - Demo Plan	11/08/19		
AD2.04	Levels 4-9 - Demo Plans	11/08/19		
AD2.05	Demo Roof Plan	11/08/19		
AD2.06	Demo Elevations	11/08/19		
A1.01	Site Plan	11/08/19	12/06/19	
A1.02	Site Plan	11/08/19	12/06/19	
A2.11	Levels 1 & 2 Floor Plans & Floor Finish Plans	11/08/19	12/06/19	
A2.12	Levels 3 & 4-9 Floor Plans & Floor Finish Plans	11/08/19		
A2.21	Levels 1 & 2 - RCP	11/08/19		
A2.22	Levels 3-9 - RCP	11/08/19		
A2.31	Roof Plan	11/08/19		
A3.01	Exterior Elevations	11/08/19		
A3.02	Exterior Elevations	11/08/19		
A4.01	Building Section	11/08/19		
A4.10	Wall Sections	11/08/19		
A6.11	Enlarged Plans	11/08/19	12/06/19	
A6.12	Enlarged Plans	11/08/19	12/06/19	
A6.21	Enlarged RCPS	11/08/19	12/06/19	
A6.22	Enlarged RCPS	11/08/19		
A6.30	Unit Schedule	11/08/19		
A6.31	Unit Plans	11/08/19	12/06/19	
A6.32	Unit Plans	11/08/19	12/06/19	
A7.01	Details - Exterior	11/08/19		
A7.11	Details - Roof	11/08/19	12/06/19	
A8.01	Interior Elevations	11/08/19	12/06/19	
A8.02	Interior Elevations	11/08/19	12/06/19	
A8.11	Unit Elevations - Bathrooms	11/08/19		
A8.12	Unit Elevations - Kitchens	11/08/19		
A9.01	Interior Details - Plan	11/08/19		
A9.02	Interior Details	11/08/19		
A9.03	Interior Details - Casework	11/08/19	12/06/19	
A9.11	Details - RCP	11/08/19		

Exhibit A.4

Index of Contract Documents

Dwg. No.	Drawing Name	Date	Add. #1	Revised
Architectural by Scott Edwards Architecture, LLP - Continued				
A10.01	Door & Window Schedules & Types	11/08/19		
A10.02	Finish Schedule	11/08/19		
Structural by ABHT Structural Engineers				
S0.01	Drawing Index and List of Abbreviations	11/08/19		
S0.02	General Structural Notes	11/08/19		
S0.03	Statement of Special Inspection	11/08/19		
S0.04	State of Special Inspection (Continued)	11/08/19		
S2.11	Level 1 Foundation Plan	11/08/19		
S2.11R	Wall Footing Reinforcing Plans	11/08/19		
S2.12	Level 2 Plan	11/08/19		
S3.01	Wall Elevations	11/08/19		
S3.02	Wall Elevations	11/08/19		
S3.03	Wall Elevations	11/08/19		
S3.04	Wall Elevations	11/08/19		
S5.01	Concrete Details	11/08/19		
S5.02	Concrete Details	11/08/19		
S6.01	Steel Details	11/08/19		
Plumbing by MFIA, Inc. (For Information Only - Design/Build Under Separate Review)				
P1.0	Foundation & First Floor Plumbing Plans - Demo (For Information Only)	100% DD Set	11/08/19	
P1.1	Second Thru Ninth Floors Plumbing Plans - Demo (For Information Only)	100% DD Set	11/08/19	
P1.2	Fourth Thru Ninth Floor and Roof Plumbing Plans - Demo (For Information Only)	100% DD Set	11/08/19	
P2.0	Foundation and First Floor Plumbing Plans - New (For Information Only)	100% DD Set	11/08/19	
P2.1	Second and Third Floor Plumbing Plans - New (For Information Only)	100% DD Set	11/08/19	
P2.2	Fourth Thru Ninth and Roof Plumbing Plans - New (For Information Only)	100% DD Set	11/08/19	
P6.0	Plumbing Legend Schedules Details (For Information Only)	100% DD Set	11/08/19	
Mechanical by Jet Industries, Inc. (For Information Only - Design/Build Under Separate Review)				
M0.01	HVAC - Legend / Sheet Index (For Information Only)	08/28/19		
M2.01	HVAC - First Floor Plan (For Information Only)	08/28/19		
M2.02	HVAC - Second Floor Plan (For Information Only)	08/28/19		
M2.03	HVAC - Third Floor Plan (For Information Only)	08/28/19		
M2.04	HVAC - Fourth Floor Plan (For Information Only)	08/28/19		
M2.05	HVAC - Fifth Floor Plan (For Information Only)	08/28/19		
M2.06	HVAC - Sixth Floor Plan (For Information Only)	08/28/19		
M2.07	HVAC - Seventh Floor Plan (For Information Only)	08/28/19		
M2.08	HVAC - Eighth Floor Plan (For Information Only)	08/28/19		
M2.09	HVAC - Ninth Floor Plan (For Information Only)	08/28/19		
M2.10	HVAC - Roof Plan (For Information Only)	08/28/19		
M3.01	HVAC - Details (For Information Only)	08/28/19		
M4.01	HVAC - Schedules (For Information Only)	08/28/19		

Exhibit A.4

Index of Contract Documents

Dwg. No.	Drawing Name	Date	Add. #1	Revised
Electrical by Merit Electric of Spokane, Inc. (For Information Only - Design/Build Under Separate Review)				
E0.01	Electrical Title Sheet (For Information Only)	09/27/19	11/15/19	
E0.02	Electrical Panel Schedules (For Information Only)		11/15/19	
E0.03	Electrical Panel Schedules (For Information Only)		11/15/19	
E0.04	Electrical Panel Schedules (For Information Only)		11/15/19	
E0.05	Electrical Panel Schedules (For Information Only)		11/15/19	
ED1.01	Site Plan Electrical Demolition (For Information Only)	09/27/19		
ED2.01	Level 1 Electrical Demolition (For Information Only)	09/27/19		
ED2.01	Electrical Demolition (For Information Only)		11/15/19	
ED2.02	Level 2 Electrical Demolition (For Information Only)	09/27/19		
ED2.03	Level 3 Electrical Demolition (For Information Only)	09/27/19		
ED2.04	Level 4-9 Electrical Demolition (For Information Only)	09/27/19		
E1.01	Site Plan - Electrical (For Information Only)	09/27/19	11/15/19	
E2.11	Level 1 & 2 Power & Signal Plan (For Information Only)	09/27/19		
E2.11	Level 1-9 Power & Signal Plan (For Information Only)		11/15/19	
E2.12	Level 3-9 Power & Signal Plan (For Information Only)	09/27/19		
E2.12	Roof Power & Signal Plan & Elevator Details (For Information Only)		11/15/19	
E2.31	Level 1 & 2 Lighting Plan (For Information Only)	09/27/19	11/15/19	
E2.32	Level 3-9 Lighting Plan (For Information Only)	09/27/19		
E2.32	Level 3-Roof Lighting Plan (For Information Only)		11/15/19	
E6.11	Level 1 - Offices & Common Areas Power & Signal Plan (For Information Only)	09/27/19		
E6.12	Level 1-2 Enlarged Electrical Plans (For Information Only)	09/27/19		
E6.21	Level 1 - Offices & Common Areas Lighting Plan (For Information Only)	09/27/19		
E6.22	Level 1-2 Enlarged Electrical Plans (For Information Only)	09/27/19		
E6.31	Typical Unit Plans (For Information Only)	09/27/19	11/15/19	
E6.32	Typical Unit Plans (For Information Only)	09/27/19	11/15/19	
Low Voltage by Point Monitor Corporation (For Information Only - Design/Build Under Separate Review)				
LV-1	General Notes (For Information Only)	09/06/19		11/04/19
LV-1	General Notes/Schedules/Lists (For Information Only)		11/14/19	
LV-2	Reserved for Future Use (For Information Only)	09/06/19	11/14/19	11/04/19
LV-3	Floor 1 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-4	Floor 2 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-5	Floor 3 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-6	Floor 4 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-7	Floor 5 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-8	Floor 6 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-9	Floor 7 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-10	Floor 8 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-11	Floor 9 (For Information Only)	09/06/19	11/14/19	11/04/19
LV-12	Roof (For Information Only)	09/06/19	11/14/19	11/04/19
LV-13	Reserved for Future Use (For Information Only)	09/06/19	11/14/19	11/04/19
Asbestos-Containing Material Survey by PBS Engineering and Environmental, Inc.				
ASB1.0	First Floor Plan (Sheet 1 of 17)	6/19		
ASB2.0	Second Floor Plan (Sheet 2 of 17)	6/19		
ASB2.1	Second Floor Plan - Ceiling Materials (Sheet 3 of 17)	6/19		
ASB3.0	Third Floor Plan (Sheet 4 of 17)	6/19		
ASB3.1	Third Floor Plan - Ceiling Materials (Sheet 5 of 17)	6/19		
ASB4.0	Fourth Floor Plan (Sheet 6 of 17)	6/19		
ASB4.1	Fourth Floor Plan - Ceiling Materials (Sheet 7 of 17)	6/19		
ASB5.0	Fifth Floor Plan (Sheet 8 of 17)	6/19		
ASB5.1	Fifth Fllor Plan - Ceiling Materials (Sheet 9 of 17)	6/19		
ASB6.0	Sixth Floor Plan (Sheet 10 of 17)	6/19		
ASB6.1	Sixth Floor Plan - Ceiling Materials (Sheet 11 of 17)	6/19		

Exhibit A.4

Index of Contract Documents

Dwg. No.	Drawing Name	Date	Add. #1	Revised
Asbestos-Containing Material Survey by PBS Engineering and Environmental, Inc. - Continued				
ASB7.0	Seventh Floor Plan (Sheet 12 of 17)	6/19		
ASB7.1	Seventh Floor Plan - Ceiling Materials (Sheet 13 of 17)	6/19		
ASB8.0	Eighth Floor Plan (Sheet 14 of 17)	6/19		
ASB8.1	Eighth Floor Plan - Ceiling Materials (Sheet 15 of 17)	6/19		
ASB9.0	Ninth Floor Plan (Sheet 16 of 17)	6/19		
ASB9.1	Ninth Floor Plan - Ceiling Materials (Sheet 17 of 17)	6/19		
SPECIFICATIONS (PROJECT MANUAL) DATED 11/8/19 AND AMENDED 12/6/19 BY SCOTT EDWARDS ARCHITECTURE, LLP				
ADDENDUM NO. 1 DATED 12/6/19 BY SCOTT EDWARDS ARCHITECTURE, LLP				

Exhibit A.5 - Wage Rates

Hillside Manor General Condtions — 3/30/2020

Ph's #	Phase	Quant	Unit	Overhead Rate	Overhead Total	Grand Total
1000	General Requirements				1,072,783	1,072,783
1101	Travel & Subsistence	67.00	wk		4,410	4,410
	Tri-Met	67.00	wk	30	2,010	
	New Hire	16.00	ea	150	2,400	
					-	
1102	Office & Utilities	67.00	wk		151,083	151,083
	Job Office Trailer 12 x 54 w/ Restroom	67.00	wk	175	11,725	
	Trailer in/out	2	ea	1,500	3,000	
	Office cleaning	67.00	wk	100	6,700	
	Office set-up/furniture	1.00	ls	1,250	1,250	
	Telephone / FAX Install	1	ls	1,750	1,750	
	Telephone / FAX Service (phone, fax, alarm lines)	67.00	wk	50.00	3,350	
	Data Service	67.00	wk	135.00	9,045	
	IP Phone -- $50/ month (per # phones)	201.00	wk	12.50	2,513	
	Cellular Telephones	166.10	wk	25.00	4,153	
	Office Trailer - Temporary Electricity- by HACC	67.00	wk		-	
	Office Trailer - Bottled Water	67.00	wk	50.00	3,350	
	Jobsite - Temporary Water Service	67.00	wk	50.00	3,350	
	Temporary Sanitary				-	
	Chemical Toilet	335.00	wk	45.00	15,075	
	Flush Toilet-Holding Tank	67.00	wk	35.00	2,345	
	Flush Toilet-Pump Tank	13,220	gal	0.50	6,610	
	Flush Toilet-Elec Conn.	1	ea	1,500.00	1,500	
	Flush Toilet-Plumb Conn.	1	ea	1,200.00	1,200	
	Office Supplies	67.00	wk	200.00	13,400	
	Computer Rental	166	wk	32.50	5,398	
	Infrastructure Access Fee	166	wk	42.50	7,059	
	Onsite End User Support	166	wk	100.00	16,610	
	Multi-function device (fax/scan/copy/print)	1	ea	7,500.00	7,500	
	AutoCAD	6	wk	250.00	1,500	
	Other - courier, misc stuff that's not in template	67.00	wk	250	16,750	
	Arc - Digital Record Set- moved to Div. 17	67.00	wk			
	Project Sign	1	ls	1,200	1,200	
	Office Alarm - Set up and Monitor	1	ls	4,750.00	4,750	
1103	Engineering & Testing				-	-
1104	Small Tools				-	-
1105	Equipment Rental				-	-
1106	Clean-Up				-	-
1107	Misc Materials					-
1108	Gas, Oil & Repairs- Moved to Div. 17	67.00	wk		-	-
	Job Supervisors Vehicle	147.34	wk		-	
1109	Hauling & Freight	67.00	wk		3,000	3,000
	Project Mobilization	1	ls	1500	1,500	
	Project Demobilization	1	ls	1500	1,500	
1110	Other	67.00	wk		-	-
1112	Safety				-	-
1113	Supervision	67.00	wk		909,290	909,290
	Project Supervision	284	wk		-	
					-	
	Project Administrator- Jill Matthews	38	wk	2296	88,050	
	Project Engineer- Justin Andersen	69	wk	3000	207,000	
	Project Engineer- May Delay - Justin Andersen	3	wk	3000	9,000	
	Resident Coordinator - Julie Cusumano	21	wk	1805	38,086	
	Project Superintendent - April/ May Delay - Jeff Copus	6	wk	3807	22,842	
	Project Superintendent -Jeff Copus	71	wk	3807	270,297	
	Project Management - Kim Smith	19	wk	3336	62,550	
	Project Management - Bennett Barnwell	48	wk	3613	171,798	
	Senior Project Management - Dan Snow	9	wk	4388	39,668	
					-	
1201	Bonds	1	ls		-	-
1203	Liability Insurance	1	ls		-	-
1204	Builders Risk Insurance	1	ls		-	-
1301	Sales Tax	1	ls		-	-
1302	B & O Tax/Licenses Tax	1	ls		-	-
1303	Permits	1	ls		-	-
1304	Hook-Up Charges	1	ls		-	-
1406	Pre-Construction Costs - separate agreement	1	ls		-	-
1504	Close-Out & Warranty	1	ls		5,000	5,000
	Close Out	1	ls	5000	5,000	

Hillside Manor -- Supervision Rates

5/21/2019

	Monthly								
	Dan Snow	Bennett Barnwell	Kim Smith	Jeff Copus	Nick Cordoza	Marty Houston	Nate Ricker	Julie Cusumano *	Jill Mathews
Base Wage	$ 13,000.00	$ 10,427.00	$ 9,512.00	$ 11,052.00	$ 7,210.00	$ 11,751.00	$ 8,335.00	$ 4,599.10	$ 6,148.00
FUTA	42.00	42.00	42.00	42.00	41.91	42.00	42.00	26.18	36.08
FICA - SS	775.31	634.07	579.41	673.75	433.07	708.72	516.77	270.57	372.81
FICA - MEDIC	181.32	148.29	135.51	157.57	101.28	165.75	120.86	63.28	87.19
OR SUTA	187.58	153.41	140.18	163.01	104.78	171.47	125.03	65.46	90.20
OR COMP	14.08	14.08	14.08	14.08	14.08	16.64	14.08	10.16	13.12
OR WORKERS COMP	210.60	168.92	154.09	179.04	1,708.38	224.98	1,063.63	21.84	27.50
TRI-MET	95.54	78.13	71.40	83.02	53.37	87.33	63.68	33.34	45.94
MEDICAL INS	1,295.36	1,295.36	1,295.36	1,295.36	1,295.36	1,295.36	1,295.36	1,295.36	1,295.36
DISAB INS	137.80	110.53	100.83	117.15	75.90	124.56	88.35	48.22	65.17
H.S.A CONTRIB	125.00	125.00	125.00	125.00	125.00	125.00	125.00	125.00	125.00
RETIREMENT	1,571.40	1,352.70	1,274.92	1,405.82	1,075.00	1,465.23	1,174.88	779.57	988.98
P.T.O - Sick, Holiday & Vacation	1,365.00	1,094.84	998.76	1,160.46	751.80	1,233.86	875.17	477.66	645.54
	$ 19,000.99	$ 15,644.33	$ 14,443.54	$ 16,468.26	$ 12,989.93	$ 17,411.90	$ 13,839.81	$ 7,815.74	$ 9,940.89

** Varies month to month as hours worked vary*

** The wage rates listed above are good through December 31, 2020. We anticipate these rates increasing by 3-4% for the project duration beyond January 1, 2021*

WASLH UNION EMPLOYEE RATES as of May 2019

Laborer-Jrny	
Wage	30.81
Craft	14.20
PR Taxes	3.87
Emp Benefits	12.56
Total Burden	61.44

Laborer-Apprentice	
Wage	26.73
Craft	14.20
PR Taxes	3.36
Emp Benefits	11.08
Total Burden	55.37

Laborer-Foreman	
Wage	32.91
Craft	14.20
PR Taxes	4.14
Emp Benefits	13.33
Total Burden	64.58

Carpenter-Jrny	
Wage	37.64
Craft	16.88
PR Taxes	4.74
Emp Benefits	12.95
Total Burden	72.21

Carpenter-Apprentice	
Wage	33.12
Craft	16.88
PR Taxes	4.17
Emp Benefits	11.55
Total Burden	65.72

Carpenter-Foreman	
Wage	42.91
Craft	16.88
PR Taxes	5.41
Emp Benefits	14.57
Total Burden	79.77

Carpenter-Layout	
Wage	41.40
Craft	16.88
PR Taxes	5.22
Emp Benefits	14.11
Total Burden	77.61

Carpenter-Skin Dr	
Wage	39.90
Craft	16.88
PR Taxes	5.03
Emp Benefits	13.64
Total Burden	75.45

* Wages above do not account for Union Rate Increase set to take effect June 1st (rate amount has not been announced)

Hillside Manor 5/15/2019

Information Technology Cost Breakdown	Cost / Wk
Computer Rental	32.50
Infrastructure Access Fee	42.50
Onsite End User Support	100.00

Computer Rental - $32.50 per week.

- Thin client, desktop, or laptop device
- Monitor
- Printer
- Standard productivity applications (MS Office, etc..)

Infrastructure Access Fee - $42.50 per week.

- Remote LAN configuration and support
- Infrastructure connectivity and security
- Infrastructure maintenance and support
- Central business applications (Viewpoint, Risk Management System, CMiC)

Onsite End User Support Agreement - $100 per week.

- Helpdesk phone support
- Onsite and depot service.
- All shipping, parts, labor and travel costs associated with service
- Hardware replacement agreement
- Software upgrade assurance
- Damage and theft replacement

Project Schedule: **67** **Wks** **3/30/2020**

GJI ---- General Jobsite Items

Category	Unit	Rate	Total Units	Grand Total
Horizontal & Vertical Control			**12**	**$ 18,924**
CAD Master-Micro Piles/ Concrete/ walls	wk	3104	6	18,624
Layout & Control--Labor	wk	3295	-	-
" " "	wk	3295	-	-
" " Materials	wk	50	6	300
Equipment			**932**	**$ 312,057**
Small Tools	wk	250	67	16,750
Forklift--56'--10000lb-	wk	1300	60	78,390
Equipment Fuel	wk	75	60	4,523
Window Box	wk	68	60	4,100
Trash box	wk	75	60	4,523
Truck Delivery/Return	ea	150	67	10,050
Container	wk	70	67	4,690
Builders Level	wk	76	24	1,824
Baloney Cords - exterior only (interior to be extension cords off of house power)	mo	480	15	6,978
Spider Boxes - 2 per month	mo	360	15	5,477
Temporary Lighting- yard	wk	50	67	3,350
Misc Equipment	wk	400	67	26,800
Tool Trailer	wk	70	-	-
Equipment Repairs	wk	50	54	2,722
Forklift Operator	wk	2583	34	86,531
Scissor Lift--Skyjack 500# 20'	wk	210	16	3,360
Hydro-Crane - Floors 7,8,9, Roof (when man-material hoist is not up)	day	2500	16	40,000
Trash chute - up/down	ea	1500	-	-
Trash chute - rental	mo	126	-	-
Crane pallet forks	wk	126	-	-
2-Way Radios	wk	45	-	-
Foreman Cell Phones- Laborer	wk	14	67	928
3 second Total Station	wk	525	6	3,150
Concrete Hi-Cycle Vibrator	wk	180	-	-
Hi-Cycle Generator	wk	125	-	-
Rebar Cutter	wk	150	-	-
Ceiling Grinder	wk	98	16	1,568
Jackhammer 90 lb	wk	90	16	1,440
Rotohammer	wk	100	40	4,020
Baker scaffold	wk	22	37	884
Engineering & Testing			**1**	**$ 5,000**
Surveyor-KC Development	ls	5000	1	5,000
Clean-Up			**67**	**$ 193,523**
Continuous Clean-Up - Interior Laborer	wk	2888	67	193,523
			-	-

Project Schedule: 67 **Wks** **3/30/2020**

GJI ---- General Jobsite Items

Category	Unit	Rate	Total Units	Grand Total
Drop-Boxes/Disposal of Debris			**0**	**$ 29,455**
Drop Boxes - Demo/Abatement Disposal by Net Compliance	sf	73637	0	29,455
			-	-
Safety	*Rate*	*Unit*	**1**	**$ 8,610**
General Safety - $100 / wk - occ. remodels	61	wk	100%	6,100
Croakies		ea		-
Dust Masks		box		-
Ear Plugs		box		-
Hard Hats		ea		-
Face Shields		ea		-
Safety Handbook		ea		-
Safety Glasses		ea		-
Safety Goggles		ea		-
Gray Replacement Lense		ea		-
Lens Cleaning Stations		ea		-
Lens Cleaning Towelettes		box		-
Harness Assembly		ea		-
Pad for Harness Assembly		ea		-
DBI Sala 6' SRL Nano		ea		-
DBI Sala 20' SRL Ultra Lok		ea		-
DBI Sala 30' SRL Nano		ea		-
Saflok Concrete wedge anchor		ea		-
Protecta Rebel 11'SRL		ea		-
Belt for Harness Assembly		ea		-
100 ft. Rope Lifeline		ea		-
3 ft. Tie-Off		ea		-
Rope Grab w/ Shock Abs.		ea		-
Roof Anchor		ea		-
DBI 18" Extender		ea		-
Fall Protection Bag		ea		-
First Aid Kit Re-Stocking - $10/ wk	61	wk		610
Defibulator - WCC Office - Install in Building at Completion - $1900	1	ea		1,900
Gas, Oil, Repairs - Supervision			**1**	**$ 12,034**
Digital Record Set/ Blueprints	*Rate*	*Unit*	**71**	**$ 10,650**
Digital Record Set/ Blueprints	150	wks	71	10,650
				-
Grand Total - GJI's				**$ 590,253**

Walsh Equipment Rates

Contractors Equipment Co.-Oregon Rental Schedule and Rates - As of 1/1/2019

Item / Description	Daily	Weekly	Monthly
AIR COMPRESSORS			
Compressor - 3 hp Tank Mounted Portable	$22	$65	$195
Compressor - Pancake	$10	$30	$90
Compressor - 160 cfm & 185 cfm tow-behind	$100	$300	$900
AIR TOOLS			
Chipping Gun (Pneumatic 30#)	$23	$69	$200
Pavement Breaker (Jackhammer) 60#	$26	$78	$230
Pavement Breaker (Jackhammer) 90#	$30	$90	$260
Rivet Buster	$30	$100	$250
BUILDING DRY-OUT			
170k BTU Natural Gas Heaters- Portable	$35	$100	$300
220v Electric Heaters- Portable	$10	$20	$40
Sure Flame- Hi-Velocity 400k btu heater	$129	$388	$1,155
Heat Wagon- 400k BTU Natural Gas/Propane Heaters- Portable	$115	$460	$920
High-Velocity Floor Fans	$20	$60	$120
Portable Dehumidifiers- 12 gallon	$40	$120	$360
Portable Dehumidifiers- 25 gallon	$60	$180	$540
COMPACTION EQUIPMENT			
Compactor - Jumping Jack-Rammer	$50	$200	$600
Compactor - Skid-Plate	$50	$195	$575
CONCRETE EQUIPMENT			
Ceiling Grinders	$33	$98	$294
60 # Electric Breaker	$50	$150	$450
Concrete Blanket-Basket	$13	$48	$147
Concrete Bucket - 2 yd	$40	$120	$360
Concrete Bucket - 3/4, 1, 1-1/2 yd	$30	$90	$270
Concrete Coring Tool - (Hand-held)	$52	$144	$412
Concrete Saws - Walk Behind or Soff-Cut Slab Saw	$58	$155	$402
Concrete Trailer - Foundation Crews	$200	$600	$1,200
Concrete Vibrators - Gas-powered backpack	$60	$180	$420
Concrete Vibrators	$30	$90	$270
Demo Saws	$45	$135	$375
Generators	$40	$120	$360
Georgia Buggy	$85	$250	$750
Mortar Mixer	$41	$139	$386
Rebar Bender - Hydraulic	$50	$150	$450
Rebar Cutter - Electric	$40	$120	$350
Rebar Cutter - Bender (Rod-Chomper)	$40	$120	$350
Aluma Post-Shore Braces	N/A	$3	$3
PERI Panels		$.60 per sq. ft.	$2.00 per sq. ft.
Rotohammers (Large)	$30	$100	$300
Concrete Slab Grab Handrails	$1	$3	$7
CONTAINERS - STORAGE			
Storage Containers, 8' x 10', no electricity	$15	$45	$120
Storage Containers, 8' x 20', lights,alarm, heat & power service	$20	$60	$180
Storage Containers, 8' x 40', lights, alarm,heat & power service	$25	$75	$225
Storage Trailer Van 27' (lights,alarm, heat, & electric service)	$18	$60	$180
EXCAVATION EQUIPMENT			
JOHN DEERE Mini-Excavators	$300	$900	$2,700
CAT Skid Steer Loader	$129	$388	$1,155
CASE 580-SL Backhoes	$225	$775	$2,300
CASE Dozer - Crawler Tractor 850-G	$340	$1,080	$2,900
Dump Trucks	$250	$1,100	$3,400
Water Truck - 2000 Gallon (Hourly $150.00)	$265	$800	$2,400
Ho-pak for CASE Backhoe	$100	$380	$1,200
KOMATSU Excavators, PC160 LC-7	$340	$1,360	$4,050
Trailer - Excavation Crew Trailer	$65	$210	$650
FUEL TANKS			
200 gallon - single wall - gas only -	$5	$20	$50
300 gallon double - wall dike tank - diesel only	$11	$37	$117
550 gallon double - wall dike tank - diesel only	$25	$48	$147
LARGE SAWS			
Radial Arm Saw	$26	$82	$232
Table Saw	$24	$55	$168
Tablesaw Powermatic Finish	$26	$82	$232
MATERIAL HANDLING - Cranes, Forklifts, Lifts, Man Basket, Window Boxes			
Boom Lifts - 60' Straight Boom -500# capacity	$350	$1,000	$3,000
Boom Lift- 80' Articulated	$700	$1,800	$4,000
Crane - Potain HDT 80 - Self-Erector (including maint. agreement)	N/A	$3,500	$10,500
Crane - LIEBHERR 281 HC Tower Crane (including maint. agreement)	N/A	$4,600	$14,000
Crane - LIEBHERR 420 EC-H 16 Tower Crane (including maint. agreement)	N/A	$6,600	$20,000
Crane Pallet Forks	$50	$150	$450
Forklifts- HYSTER Lift Truck, 5000# capacity, propane	$130	$400	$1,200

Forklifts- SKYJACK VR-1056 (56'-10k)	$400	$1,300	$3,800
Forklifts- INGERSOLL-RAND VR-843 (43'-8k)	$350	$1,100	$3,200
Forklift-Low profile (6'11") RT Forklift - 16'5" lift height w/ 4400# capacity	$200	$600	$1,800
2' Truss Boom attachment for RT Forklifts	$40	$120	$300
Genie Lifts, 650 lbs.	$35	$110	$270
Man-basket (personnel platform)	$21	$68	$205
Scissor Lift- SKYJACK 500# capacity- 19' platform height	$70	$210	$500
Window Basket - 5' x 10'	$21	$68	$205
PAINT EQUIPMENT			
Paint spray pump - 500 & 600 ULTRA & 447E TITAN	$33	$108	$330
Paint spray pumps - ULTRA 1500 & 1000 or SPEEDO 4500	$61	$183	$551
Adhesive spray pump	$200	$400	$800
Painters' Van	$36	$118	$361
PRESSURE WASHERS			
Pressure Washer - Cold Water - 2500 psi & 3500 psi	$52	$160	$485
RADIOS / COMMUNICATIONS			
Radios : 2-Way	$15	$45	$100
SIDING EQUIPMENT			
Siding Trailer-including siding tools	$95	$285	$850
Aluma-Pole Pump Jacks- per set	$50	$100	$300
SAFETY/SECURITY EQUIPMENT			
Manhole Tripod with winch	$99	$328	$985
Roof top anchor sytem - Flat roofs	$75	$200	$600
Wireless Video Surveillance System	$25	$125	$250
Yo-Yo (Controlled Descent Block)	$25	$75	$200
SCAFFOLDING			
Baker Scaffold - 1 section w/ plank & handrails	$15	$51	$150
SURVEY & PRECISION MEASURING EQUIPMENT			
Builder's Level	$34	$76	$230
Digital Transits	$40	$100	$310
Lasers - (RL-VH & Laser Theodolite)	$75	$210	$625
Lasers (LB-1, LB-2, LB-10)	$50	$150	$450
Pipe Laser	$100	$300	$900
3-Second Total Station	$175	$525	$1,550
Total Station	$150	$450	$1,350
TEMPORARY POWER			
Temporary Power Box (Spider Box)	$30	$90	$180
50' Baloney Cord	$15	$45	$120
200 Amp Service Panel	$10	$30	$90
TRASH BOXES & CHUTES			
Trash Box - Crane-Clamshell	$25	$75	$250
Trash Box - Crane - 4 yd self-dumping	$50	$150	$450
Trash Box - 5' x 10' front opening	$25	$75	$250
Trash Chute	$25	$75	$250
TRUCKS - Pickup & Delivery Trips Within a Distance of:	*50 Miles*	*100 Miles*	*200 Miles*
Dodge 1-1/2 Ton Flatbeds	$50	$100	$150
Dodge 5 Ton flatbed	$65	$135	$200
Dodge- Service Truck	$50	$100	$150
Volvo with 48' Equipment/Material Hauler		$90 Per Hour -	
Kenworth 24' Flatbed	$80	$160	$250
Storage Trailers			
Storage Trailers- 45' & 48'	$20	$70	$200
WELDERS & CUTTING TORCHES			
Cutting Torch w/ Tanks	$25	$75	$225
Welder	$29	$87	$234
MISCELLANEOUS - Banders, Drills, Framing Boxes, Pumps, etc.			
Bander w/ Cart	$15	$50	$150
Framing Box (steel)	$14	$39	$106
Backpack Blower	$15	$45	$135
Wobble lights	$10	$20	$40
Magnetic Drill Press	$40	$120	$360
Sump Pumps - 2"	$30	$90	$270
Chain Saws	$10	$30	$100
Negative Air Machine- Medium	$40	$120	$230
Negative Air Machine- Large	$50	$150	$350
Picking Eye- for steel plates	$12	$36	$120
Large Steel Plates	$25	$75	$200
Tool Skips 4x4 (wood sides)	$8	$25	$77

COMPANY:

ATTENTION:

2019 RENTAL RATES

DESCRIPTION OF EQUIPMENT	RATES		
SCISSOR LIFTS	***DAILY***	***WEEKLY***	***MONTHLY***
12' ELECTRIC SINGLE MAN LIFT	$125.00	$275.00	$650.00
13' ELECTRIC SCISSOR LIFT	$125.00	$275.00	$650.00
15' ELECTRIC SINGLE MAN LIFT	$160.00	$400.00	$800.00
20' ELECTRIC SINGLE MAN LIFT	$175.00	$450.00	$875.00
19' ELECTRIC SCISSOR LIFT	$175.00	$450.00	$875.00
26' ELECTRIC NARROW SCISSOR LIFT	$225.00	$500.00	$1,095.00
26' ELECTRIC WIDE SCISSOR LIFT	$225.00	$500.00	$1,095.00
32' ELECTRIC SCISSOR LIFT	$260.00	$575.00	$1,200.00
40' ELECTRIC SCISSOR LIFT	$275.00	$650.00	$1,375.00
32' ROUGH TERRAIN SCISSOR LIFT 4x4	$300.00	$725.00	$1,625.00
43' ROUGH TERRAIN SCISSOR LIFT 4x4	$400.00	$975.00	$1,975.00
50' ROUGH TERRAIN SCISSOR LIFT 4x4	$550.00	$1,375.00	$2,850.00
BOOM LIFTS	***DAILY***	***WEEKLY***	***MONTHLY***
30' ARTICULATING ELECTRIC	$345.00	$950.00	$1,975.00
34' ARTICULATING ELECTRIC	$355.00	$975.00	$2,050.00
40' ARTICULATING ELECTRIC	$365.00	$1,000.00	$2,100.00
45' ARTICULATING ELECTRIC	$375.00	$1,100.00	$2,200.00
34' ARTICULATING ROUGH TERRAIN 4x4	$400.00	$1,000.00	$2,100.00
45' ARTICULATING ROUGH TERRAIN 4x4	$445.00	$1,250.00	$2,500.00
60' ARTICULATING ROUGH TERRAIN 4x4	$625.00	$1,750.00	$3,600.00
63' ARTICULATING ROUGH TERRAIN 4x4	$625.00	$1,750.00	$3,600.00
80' ARTICULATING ROUGH TERRAIN 4x4	$1,000.00	$3,000.00	$6,975.00
45' STRAIGHT BOOM W/JIB 4x4 DUAL FUEL	$395.00	$1,150.00	$2,300.00
65' STRAIGHT BOOM W/JIB 4x4 DIESEL	$575.00	$1,650.00	$3,400.00
85' STRAIGHT BOOM W/JIB 4x4 DUAL FUEL	$950.00	$2,800.00	$6,275.00
135' STRAIGHT BOOM W/JIB 4x4 DIESEL	$2,050.00	$5,100.00	#########
OFF ROAD REACH FORKLIFTS	***DAILY***	***WEEKLY***	***MONTHLY***
5,500LB REACH FORKLIFT (19' REACH NO OUTRIGGER	$350.00	$1,000.00	$2,400.00
6K REACH FORKLIFT (36' REACH NO OUTRIGGERS)	$375.00	$1,100.00	$2,750.00
8K REACH FORKLIFT (43' REACH NO OUTRIGGERS)	$565.00	$1,695.00	$3,950.00
10K REACH FORKLIFT (44' REACH NO OUTRIGGERS)	$625.00	$1,850.00	$4,850.00
10K REACH FORKLIFT (56' REACH WITH OUTRIGGERS)	$675.00	$1,900.00	$4,995.00
12K REACH FORKLIFT (56' REACH WITH OUTRIGGERS)	$750.00	$2,125.00	$5,300.00
SWING CARRIAGE ATTACHMENT	$125.00	$275.00	$650.00
TRUSS BOOM/JIB BOOM	$75.00	$175.00	$525.00
DIRT BUCKET	$75.00	$175.00	$525.00
BIN DUMPER (SELF DUMPING HOPPER)	$100.00	$250.00	$600.00
OFF ROAD STRAIGHT MAST FORKLIFT	***DAILY***	***WEEKLY***	***MONTHLY***
6K ROUGH TERRAIN STRAIGHT MAST FORKLIFT	$285.00	$875.00	$2,095.00
SINGLE DRUM ROLLERS/COMPACTORS	***DAILY***	***WEEKLY***	***MONTHLY***
11,000lb WITH 54" SMOOTH DRUM	$450.00	$1,400.00	$3,300.00
11,000lb WITH 54" PAD FOOT	$475.00	$1,450.00	$3,400.00
DOUBLE DRUM ROLLERS/COMPACTORS	***DAILY***	***WEEKLY***	***MONTHLY***
3,600lb 36" DOUBLE DRUM	$225.00	$700.00	$1,750.00
5,700lb 47" DOUBLE DRUM	$275.00	$850.00	$2,500.00
UTILITY VEHICLES	***DAILY***	***WEEKLY***	***MONTHLY***
JOHN DEERE 4X4 GATOR (2 SEATER)	$140.00	$425.00	$1,150.00
JOHN DEERE 4X4 GATOR (4 SEATER)	$155.00	$450.00	$1,325.00

DESCRIPTION OF EQUIPMENT	RATES		
AIR COMPRESSORS	***DAILY***	***WEEKLY***	***MONTHLY***
185CFM DIESEL AIR COMPRESSOR (100PSI)	$150.00	$575.00	$1,200.00
375CFM DIESEL AIR COMPRESSOR (125PSI)	$295.00	$975.00	$2,095.00
750CFM DIESEL AIR COMPRESSOR (150PSI)	$565.00	$1,575.00	$4,500.00
825CFM DIESEL AIR COMPRESSOR (125PSI)	$575.00	$1,600.00	$4,550.00
XHP750CFM DIESEL AIR COMPRESSOR(300PSI)	$895.00	$2,475.00	$6,725.00
XHP1170CFM DIESEL AIR COMPRESSOR (350PSI)	$1,375.00	$3,400.00	$10,200.00
900CFM ELECTRIC AIR COMPRESSOR (150PSI)	$615.00	$1,695.00	$5,000.00
1600CFM IQ DIESEL AIR COMPRESSOR (150PSI)	$1,000.00	$2,700.00	$7,250.00
AIR COMPRESSOR HOSE	***DAILY***	***WEEKLY***	***MONTHLY***
3/4" 50' AIR HOSE	$10.00	$30.00	$60.00
2" 50' AIR HOSE	$50.00	$140.00	$385.00
3" 25' AIR HOSE	$55.00	$165.00	$495.00
AIR TOOLS	***DAILY***	***WEEKLY***	***MONTHLY***
RIVET BUSTER	$65.00	$140.00	$400.00
60LB PAVEMENT BREAKER	$75.00	$150.00	$425.00
90LB PAVEMENT BREAKER	$95.00	$165.00	$450.00
POINT/CHISEL WEAR CHARGE	$5 PER BIT USED		
ELECTRIC BREAKERS	***DAILY***	***WEEKLY***	***MONTHLY***
60LB ELECTRIC BREAKER	$75.00	$150.00	$425.00
GENERATORS	***DAILY***	***WEEKLY***	***MONTHLY***
2000 WATT PORTABLE GENERATOR	$75.00	$225.00	$550.00
3000 WATT PORTABLE GENERATOR	$95.00	$275.00	$725.00
G25 TOWABLE DIESEL GENERATOR (25kVA/20kW)	$225.00	$650.00	$1,650.00
G40 TOWABLE DIESEL GENERATOR (39kVA/31kW)	$225.00	$650.00	$1,650.00
G50 TOWABLE DIESEL GENERATOR (48kVA/38kW)	$275.00	$760.00	$1,950.00
G70 TOWABLE DIESEL GENERATOR (70kVA/56kW)	$350.00	$900.00	$2,475.00
G90 TOWABLE DIESEL GENERATOR (94kVA/75kW)	$425.00	$1,300.00	$3,000.00
G125 TOWABLE DIESEL GENERATOR (125kVA/100kW)	$500.00	$1,500.00	$3,650.00
G190 TOWABLE DIESEL GENERATOR (181kVA/145kW)	$600.00	$1,595.00	$4,500.00
G290 TOWABLE DIESEL GENERATOR (290kVA/207kW)	$650.00	$1,975.00	$5,395.00
SPIDER BOX	$65.00	$175.00	$350.00
50' SPIDER BOX CABLE	$50.00	$150.00	$300.00
LIGHT TOWERS	***DAILY***	***WEEKLY***	***MONTHLY***
TOWABLE LIGHT TOWER (HALOGEN)	$150.00	$400.00	$800.00
TOWABLE LIGHT TOWER (LED)	$175.00	$450.00	$900.00
DITCH WITCH VACUUM TRAILERS	***DAILY***	***WEEKLY***	***MONTHLY***
FX30 (500 GALLON)	$500.00	$1,500.00	$4,250.00
WATER TRAILER WITH PUMP	***DAILY***	***WEEKLY***	***MONTHLY***
500 GALLON WATER TRAILER	$175.00	$500.00	$1,100.00
WATER PUMPS	***DAILY***	***WEEKLY***	***MONTHLY***
2" SUBMERSIBLE	$60.00	$160.00	$400.00
25' SUCTION HOSE	$20.00	$50.00	$100.00
WALK BEHIND PLATE COMPACTORS	***DAILY***	***WEEKLY***	***MONTHLY***
210lb GAS COMPACTOR	$95.00	$375.00	$850.00
1,000lb DIESEL REVERSIBLE COMPACTOR	$315.00	$950.00	$2,095.00
JUMPING JACKS	***DAILY***	***WEEKLY***	***MONTHLY***
JUMPING JACK COMPACTOR	$100.00	$400.00	$875.00
EQUIPMENT TRAILERS	***DAILY***	***WEEKLY***	***MONTHLY***
10,000lb DUAL AXLE	$125.00	$415.00	$875.00

PAPÉ Rents

DESCRIPTION OF EQUIPMENT	RATES		
SKIDSTEER LOADERS	***DAILY***	***WEEKLY***	***MONTHLY***
BOBCAT S70 MINI SKIDSTEER	$175.00	$600.00	$1,500.00
JOHN DEERE 318 SKIDSTEER	$225.00	$775.00	$2,200.00
JOHN DEERE 320 SKIDSTEER	$240.00	$800.00	$2,250.00
JOHN DEERE 332/BOBCAT S770 H.F. SKIDSTEER	$325.00	$1,000.00	$2,700.00
PLANER PACKAGE	$675.00	$2,500.00	$6,750.00
RUBBER TRACK SKIDSTEER LOADERS	***DAILY***	***WEEKLY***	***MONTHLY***
BOBCAT T450 TRACK LOADER	$275.00	$825.00	$2,550.00
JOHN DEERE 323/BOBCAT T590 TRACK LOADER	$275.00	$825.00	$2,550.00
JOHN DEERE 331 TRACK LOADER	$325.00	$1,000.00	$2,750.00
JOHN DEERE 333/BOBCAT T770 H.F. TRACK LOADER	$350.00	$1,050.00	$2,995.00
FORESTRY PACKAGE	$1,050.00	$3,100.00	$8,350.00
WALK BEHIND MINI TRACK LOADERS	***DAILY***	***WEEKLY***	***MONTHLY***
36" WIDE WALK BEHIND TRACK LOADER	$185.00	$550.00	$1,595.00
44" WIDE WALK BEHIND TRACK LOADER	$215.00	$625.00	$1,850.00
COMPACT EXCAVATORS	***DAILY***	***WEEKLY***	***MONTHLY***
BOBCAT 418 MINI EXCAVATOR	$235.00	$675.00	$1,925.00
JOHN DEERE 17G	$250.00	$695.00	$2,000.00
JOHN DEERE 35G/BOBCAT E32	$325.00	$975.00	$2,850.00
JOHN DEERE 50G/BOBCAT E50	$385.00	$1,150.00	$3,400.00
JOHN DEERE 85G/BOBCAT E85	$460.00	$1,375.00	$4,095.00
SKIDSTEER/EXCAVATOR ATTACHMENTS	***DAILY***	***WEEKLY***	***MONTHLY***
ANGLE BROOM	$150.00	$495.00	$1,100.00
AUGER POWER HEAD (INCLUDES ONE BIT)	$125.00	$350.00	$825.00
AUGER BIT ALONE	$2/INCH	$4/INCH	$10/INCH
BREAKER	$195.00	$700.00	$2,000.00
BRUSHCAT	$250.00	$750.00	$2,250.00
FORKS	$50.00	$140.00	$300.00
GRAPPLE BUCKET	$110.00	$295.00	$625.00
LANDSCAPE RAKE (COLLECTS ROCKS FROM SOIL)	$185.00	$595.00	$1,425.00
PLATE COMPACTOR	$110.00	$350.00	$825.00
SOIL CONDITIONER	$150.00	$485.00	$1,100.00
SWEEPER	$125.00	$425.00	$935.00
TILLER	$125.00	$400.00	$875.00
TREE SPADE	$325.00	$1,100.00	$2,900.00
TRENCHER 3FT	$125.00	$350.00	$715.00

DESCRIPTION OF EQUIPMENT	RATES		
INDUSTRIAL FORKLIFT CUSHION TIRE	***DAILY***	***WEEKLY***	***MONTHLY***
S30XM/FT (192" 3 stage mast)	$165.00	$495.00	$1,452.00
S50XM/FT (187" 3 stage mast)	$215.00	$622.00	$1,843.00
S60XM/FT (189" 3 stage mast)	$226.00	$660.00	$1,958.00
S60XM/FT (240" 4 stage mast)	$242.00	$710.00	$2,096.00
S80XM/FT (194" 3 stage mast)	$259.00	$765.00	$2,244.00
S120XM/FT (184" 3 stage mast)	$325.00	$957.00	$2,838.00
S155XL (173.5" 2 stage mast)	$358.00	$1,062.00	$3,157.00
INDUSTRIAL FORKLIFT PNUEMATIC TIRE	***DAILY***	***WEEKLY***	***MONTHLY***
H30-35XM/FT (189" 3 stage mast)	$182.00	$523.00	$1,535.00
H40XMS (189" 3 stage mast)	$204.00	$589.00	$1,738.00
H50XM/FT (189" 3 satge mast)	$209.00	$622.00	$1,843.00
H50XM (171" 3 stage mast)	$242.00	$710.00	$2,101.00
H60FT (189" 3 stage mast)	$248.00	$748.00	$2,217.00
H90XM/FT (174" 3 satge mast)	$270.00	$803.00	$2,387.00
H120XM (175" 3 satge mast)	$297.00	$897.00	$2,668.00
H155XL/FT (170" standard)	$380.00	$1,133.00	$3,383.00
H190-210HD (212" standard)	$600.00	$1,788.00	$5,335.00
H360HD (180" standard)	$814.00	$2,426.00	$7,260.00
H360/48	$1,062.00	$3,179.00	$9,460.00
H550FS (124" 3 stage mast)	$1,298.00	$3,894.00	$11,660.00
ELECTRIC FORKLIFT	***DAILY***	***WEEKLY***	***MONTHLY***
J35-40ZT (189" 3 stage mast)	$204.00	$594.00	$1,755.00
E50XM/Z (187" 3 stage mast)	$231.00	$677.00	$2,013.00
E50XM/Z (240" 4 stage mast)	$248.00	$732.00	$2,156.00
N40ZRS (121" 3 stage mast)	$165.00	$495.00	$1,458.00
R30XMS (213" 3 stage mast)	$165.00	$495.00	$1,458.00
W40Z	$88.00	$242.00	$688.00
B60Z	$110.00	$330.00	$990.00
FORKLIFT ATTACHMENTS	***DAILY***	***WEEKLY***	***MONTHLY***
PAPER ROLL CLAMPS II & III	$143.00	$385.00	$1,128.00
PAPER ROLL CLAMPS IV	$143.00	$413.00	$1,205.00
PUSH PULL	$143.00	$259.00	$743.00
BALE CLAMP	$143.00	$297.00	$853.00
ROTATOR	$143.00	$259.00	$743.00
SCOOP	$143.00	$303.00	$875.00
EXTRA LP TANK	$11.00	$28.00	$55.00

TRANSPORTATION CHARGES:		
WITHIN 30 MIN OF YARD	$125.00	$125.00
WITHIN 60 MIN OF YARD	$150.00	$150.00
MORE THAN 60 MIN OF YARD	$150 PER HR	
OUTSIDE CONTRACT HAULING	$150 PER HR	

EQUIPMENT REFUELING CHARGE	***GALLON***
DIESEL	$7.50
LP (propane)	$7.50

*fuel price can change without notice

*ALL EQUIPMENT RENTED SUBJECT TO A $300 CLEANING FEE IF RETURNED DIRTY.

*18% LOSS DAMAGE WAIVER CHARGE WILL BE ADDED TO ALL INVOICES, FOR CUSTOMERS WITHOUT ACCEPTABLE INSURANCE ON FILE.

*EACH RENTAL COMES WITH A FULL TANK OF FUEL. CUSTOMER RESPONSIBLE TO REFUEL BEFORE RETURNING.

*CUSTOMER WILL BE CHARGED PER GALLON FOR ANY REFUELING NEEDED, IF RETURNED EMPTY OR NOT FULL.

*QUOTE BASED ON MAX HOUR USAGE OF: 8 HOURS PER DAY, 40 HOURS PER WEEK, 160 HOURS PER MONTH. OVER HOURS USAGE WILL BE CHARGED ACCORDINGLY.

QUOTE VALID THROUGH DECEMBER 31st, 2018

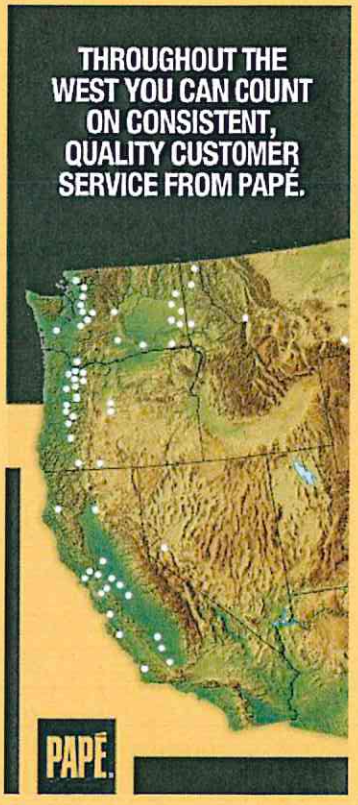
Thank you for this opportunity to submit a quote to your company! Please do not hesitate to contact me directly at the number below, with any questions or concerns you might have.

SALESMAN NAME

POSITION

000-000-0000

EMAIL ADDRESS



OREGON LOCATIONS:

CLACKAMAS OREGON

13850 SE Ambler Rd, Clackamas OR 97015

Office (503) 278-3530

Toll free 888-813-2580

MEDFORD OREGON

500 Pech Rd, Central Point OR 97502

Office (541) 779-3444

Toll free 888-813-2580

EUGENE OREGON

29550 Airport Rd, Eugene OR 97402

Office (541) 689-7407

Toll free 888-813-2580

TIGARD OREGON

7000 SW Sandburg St, Portland Oregon 97223

Office (503) 639-8910

Toll free 888-813-2580

Star Rentals

Key	Owned	In	Name	Sell	Daily	Weekly	Monthly
			FORKLIFTS INDUSTRIAL				
155-0030	213	31	FORKLIFT, IND 5000#		$ 150.00	$ 535.00	$ 1,270.00
155-0032	4	1	FORKLIFT, IND 5000# 20'		$ 200.00	$ 600.00	$ 1,450.00
155-0035	4	0	FORKLIFT, IND 6000#		$ 180.00	$ 650.00	$ 1,400.00
155-0040	3	1	FORKLIFT, IND 9000#		$ 200.00	$ 725.00	$ 1,575.00
			FORKLIFTS REACH				
145-0020	23	1	FORKLIFT, 16'-5000#		$ 200.00	$ 660.00	$ 1,595.00
150-0010	71	5	FORKLIFT, 16/19'5000# 4WD		$ 225.00	$ 790.00	$ 1,950.00
150-0050	47	3	FORKLIFT, 35'6000# 4WD		$ 235.00	$ 845.00	$ 2,020.00
150-0070	89	7	FORKLIFT, 40-42'6000# 4WD		$ 330.00	$ 1,200.00	$ 2,600.00
150-0080	82	2	FORKLIFT, 40-42'8000# 4WD		$ 360.00	$ 1,315.00	$ 2,850.00
150-0090	9	0	FORKLIFT, 44-48'10000# 4WD		$ 445.00	$ 1,615.00	$ 3,850.00
150-0100	60	1	FORKLIFT, 55'10000# 4WD		$ 490.00	$ 1,775.00	$ 4,620.00
150-0105	1	0	FORKLIFT, 42-44'12000# 4WD		$ 490.00	$ 1,775.00	$ 4,620.00
150-0107	1	0	FORKLIFT, 55'12000# 4WD		$ 520.00	$ 1,980.00	$ 5,400.00
150-0110	2	1	FORKLIFT, 44'20000# 4WD		$1,580.00	$ 5,775.00	$ 15,000.00
			BOOMLIFTS ARTICULATED				
240-0010	25	5	BOOMLIFT 30-34'ARTI GAS/EL		$ 225.00	$ 600.00	$ 1,560.00
240-0015	49	15	BOOMLIFT, NARROW ARTI 30'		$ 235.00	$ 855.00	$ 1,850.00
240-0016	7	2	BOOMLIFT, NARROW ARTI 34'		$ 245.00	$ 900.00	$ 1,950.00
240-0017	8	2	BOOMLIFT, ARTIC 33' LIGHTWEIGHT		$ 235.00	$ 855.00	$ 1,850.00
240-0018	4	1	BOOMLIFT, 34'ARTI 4WD		$ 235.00	$ 855.00	$ 1,850.00
240-0020	63	10	BOOMLIFT, 41-45'ARTI GAS/EL		$ 245.00	$ 900.00	$ 1,950.00
240-0030	56	4	BOOMLIFT , 41-45' ARTI 4WD		$ 260.00	$ 945.00	$ 2,050.00
240-0040	2	0	BOOMLIFT, 60' ARTI		$ 490.00	$ 1,335.00	$ 3,465.00
240-0050	26	3	BOOMLIFT, 60' ARTI 4WD		$ 550.00	$ 1,550.00	$ 3,500.00
240-0055	9	0	BOOMLIFT 80' ARTI 4WD/4WS		$ 990.00	$ 3,100.00	$ 6,800.00
			BOOMLIFTS STRAIGHT				
240-0070	5	1	BOOMLIFT, 40-42' ST		$ 260.00	$ 945.00	$ 2,050.00
240-0075	116	11	BOOMLIFT, 40-42' ST 4WD		$ 295.00	$ 1,060.00	$ 2,300.00
240-0076	9	1	BOOMLIFT, 40' 6'JIB 4WD		$ 315.00	$ 1,155.00	$ 2,530.00
240-0085	114	11	BOOMLIFT, 60' ST 4WD		$ 490.00	$ 1,335.00	$ 3,465.00
240-0086	3	1	BOOMLIFT, 60' ST 4WD ELEC		$ 490.00	$ 1,335.00	$ 3,465.00
240-0088	43	3	BOOMLIFT, 60' 5'JIB 4WD		$ 530.00	$ 1,460.00	$ 3,780.00
240-0096	27	3	BOOMLIFT, 80' W/5'JIB 4X4		$ 995.00	$ 3,200.00	$ 7,100.00
240-0100	2	1	BOOMLIFT, 120' 4X4 ROT JIB		$1,600.00	$ 5,200.00	$ 13,900.00
240-0105	14	1	BOOMLIFT, 125' 4X4		$1,600.00	$ 5,200.00	$ 13,900.00
240-0110	7	2	TOW-A-LIFT, 32'		$ 205.00	$ 765.00	$ 1,620.00
240-0120	9	3	TOW-A-LIFT 50'		$ 275.00	$ 985.00	$ 2,035.00

Key	Owned	In	Name	Sell	Daily	Weekly	Monthly
			MANLIFTS & SCISSOR LIFTS				
245-0010	17	6	MANLIFT, 24' AWP STYLE		$ 100.00	$ 290.00	$ 585.00
245-0011	25	4	MANLIFT, 24' IWP STYLE		$ 100.00	$ 290.00	$ 585.00
245-0016	26	13	MANLIFT, 30'PUSHRND VER		$ 110.00	$ 320.00	$ 625.00
245-0030	4	2	MANLIFT, 12' SP		$ 80.00	$ 225.00	$ 455.00
245-0035	6	2	MANLIFT, 12' SP W/EXT		$ 105.00	$ 275.00	$ 640.00
245-0036	129	59	MANLIFT, 12' SP W/EXT HYBRID		$ 105.00	$ 275.00	$ 640.00
245-0038	260	39	MANLIFT, 15' SP W/EXT		$ 120.00	$ 330.00	$ 760.00
245-0039	81	14	MANLIFT, 20' SP W/EXT		$ 125.00	$ 460.00	$ 1,000.00
245-0040	1	0	SCISSOR, 15' VERT		$ 105.00	$ 275.00	$ 640.00
245-0050	1,189	168	SCISSOR, 19' VERT		$ 120.00	$ 330.00	$ 760.00
245-0067	297	61	SCISSOR, 26' ULTRA NAR(32")		$ 125.00	$ 460.00	$ 1,000.00
245-0070	123	32	SCISSOR, 26' VERT		$ 125.00	$ 460.00	$ 1,000.00
245-0080	27	16	SCISSOR, 26' ELEC 4WD		$ 175.00	$ 620.00	$ 1,350.00
245-0083	27	5	SCISSOR, 26-27'GAS/4WD		$ 175.00	$ 620.00	$ 1,350.00
245-0084	12	5	SCISSOR, 32' ULTRA NAR (32")		$ 180.00	$ 650.00	$ 1,260.00
245-0085	252	52	SCISSOR, 32' NARROW		$ 160.00	$ 580.00	$ 1,250.00
245-0090	6	3	SCISSOR, 32' ELEC		$ 180.00	$ 650.00	$ 1,260.00
245-0095	24	8	SCISSOR, 32' ELEC 4WD		$ 195.00	$ 715.00	$ 1,395.00
245-0096	1	0	SCISSOR, 30' ELEC 4WD		$ 340.00	$ 940.00	$ 2,030.00
245-0097	12	2	SCISSOR, 31-32' GAS 4WD		$ 195.00	$ 715.00	$ 1,395.00
245-0105	23	2	SCISSOR, 35' GAS 4WD		$ 230.00	$ 725.00	$ 1,620.00
245-0106	47	21	SCISSOR, 40' ELEC		$ 290.00	$ 875.00	$ 1,695.00
245-0107	21	6	SCISSOR, 37-40' ELEC 4WD		$ 255.00	$ 925.00	$ 2,000.00
245-0115	25	8	SCISSOR, 40' GAS 4WD		$ 265.00	$ 830.00	$ 1,890.00
245-0130	17	5	SCISSOR, 50-53' GAS 4WD		$ 330.00	$ 1,200.00	$ 3,120.00

Prepared for: Walsh Construction Co/Oregon
Attn: Jill Mathews / Bennett Barnwell
On: 05/13/2019
By: Brian Crismon

SUNSTATE EQUIPMENT CO.
5413 NE COLUMBIA BLVD
PORTLAND, OR 97218

Rental Proposal

	Day	Week	4-Week
Aerial			
Boom Lift			
BOOM LIFT-45' ARTICULATING 4WD ENGINE	370	1045	2530
BOOM LIFT-60' ARTICULATING 4WD ENGINE	460	1415	3140
BOOM LIFT-45' TELESCOPIC 4WD ENGINE	360	1055	2420
BOOM LIFT-65' TELESCOPIC 4WD ENGINE	495	1620	3630
BOOM LIFT-85' TELESCOPIC 4WD ENGINE	870	2485	7065
BOOM LIFT-GLAZIER PACKAGE	30	100	200
Air Compressors and Tools			
Air Compressors			
AIR COMPRESSOR-185CFM TOWABLE DIESEL	165	485	1230
AIR COMPRESSOR-6.5CFM PORTABLE ELECTRIC	45	135	340
AIR COMPRESSOR-8.5CFM PORTABLE	45	145	350
Earth Moving			
Excavator			
MINI EX-6,000# ROPS	305	770	2105
MINI EX-8,000# ROPS	375	920	2055
MINI EX-10,500# CAB	470	1210	3425
MINI EX-18,000# CAB	550	1800	4365
TRAILER-500 GALLON VAC W/25' HOSE 2 AXLE	420	1515	3735
Material Handling			
Forklift			
FORKLIFT-20' 4,500# 2WD STRAIGHT MAST	285	685	1755
FORKLIFT-18' 4,400# 4WD TELEHANDLER	345	935	2210
FORKLIFT-42' 6,000# 4WD TELEHANDLER	430	1100	2575
FORKLIFT-42' 8,000# 4WD TELEHANDLER	475	1265	3025
FORKLIFT-54' 10,000# 4WD TELEHANDLER	580	1505	4340
FORKLIFT-55' 12,000# 4WD TELEHANDLER	705	2110	4980
General Construction Tools			
Lighting			
LIGHT-4000 WATT VERT MAST TOWER TOWABLE	115	330	805
Aerial			
Scissor Lift			
SCISSOR LIFT-19' 2WD ELECTRIC	165	375	675
SCISSOR LIFT-26' 2WD NARROW ELECTRIC	235	515	1035
SCISSOR LIFT-26' 2WD STANDARD ELECTRIC	235	515	1035
SCISSOR LIFT-32' 2WD NARROW ELECTRIC	290	615	1300
SCISSOR LIFT-26' 4WD ENGINE	300	695	1575
SCISSOR LIFT-33' 4WD ENGINE LARGE DECK	375	960	2565
SCISSOR LIFT-32' 4WD ENGINE	315	815	2190
SCISSOR LIFT-41'/43' 4WD ENGINE	355	1010	2665
Earth Moving			
Loaders			

****Estimate Purpose Only****

**Plus Any And All Applicable Fuel Charges, Taxes, Damage Waiver, or Fee's;

PROPOSAL GOOD FOR 30 DAYS - We reserve the right to change rates at any time.

	Day	Week	4-Week
LOADER-SKID 68"	290	790	1825
LOADER-TRACK SKID 68"/78" CAB&HIGH FLOW	425	1300	2895

Transportation Rates

$125 Delivery and Pickup

Special Notes

Accepted By:_____ Date:_____

Estimate Purpose Only

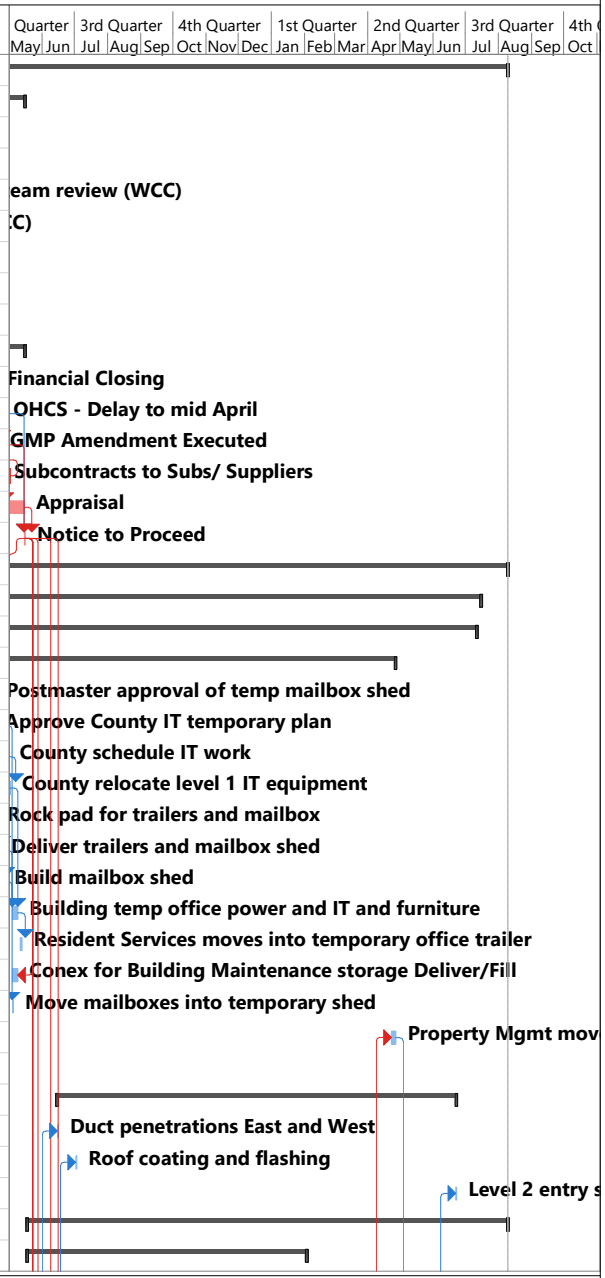
**Plus Any And All Applicable Fuel Charges, Taxes, Damage Waiver, or Fee's;

PROPOSAL GOOD FOR 30 DAYS - We reserve the right to change rates at any time.

Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

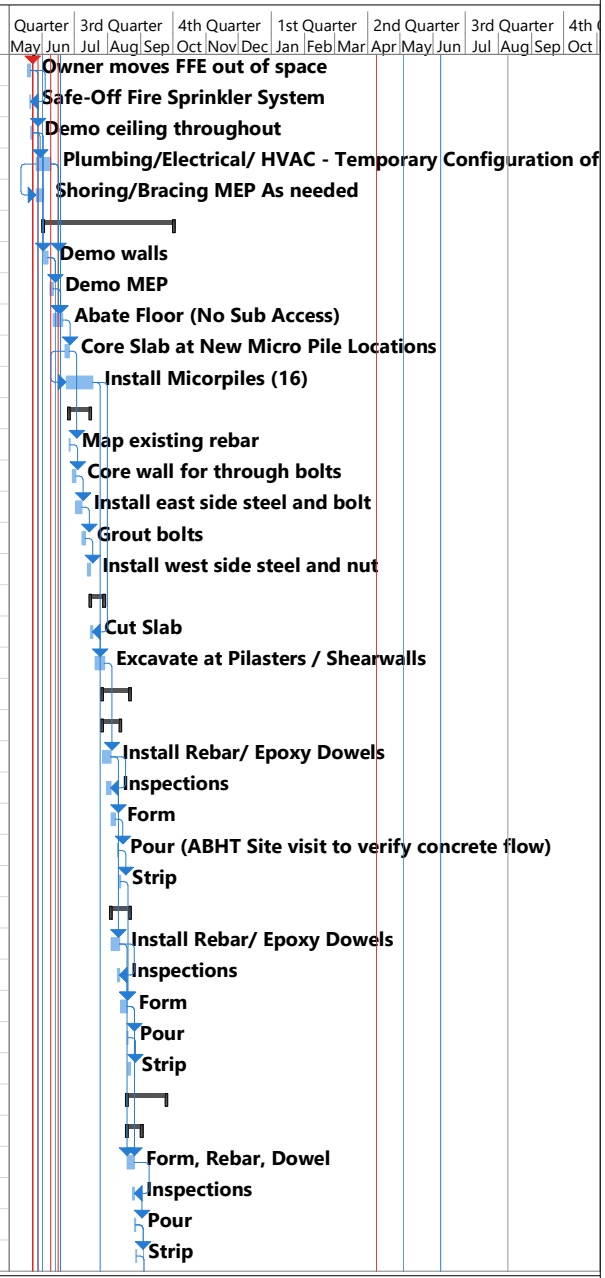
ID	Task Name	Duration	Start	Finish
1	**Hillside Manor (Construction Starts May 15 2020)**	**651 days**	**Tue 1/15/19**	**Mon 8/9/21**
2	**Preconstruction**	**280 days**	**Tue 4/9/19**	**Fri 5/15/20**
3	Prioritization Budget Due	0 days	Tue 4/9/19	Tue 4/9/19
4	HACC Review and Feedback	29 days	Tue 4/9/19	Fri 5/17/19
5	Draft prioritization budget due for team review (WCC)	15 days	Mon 5/20/19	Mon 6/10/19
6	Final prioritization budget due (WCC)	5 days	Tue 6/11/19	Mon 6/17/19
7	**MEP, Storefront, Micro Pile Bid Package**	**27 days**	**Mon 7/1/19**	**Fri 8/9/19**
12	**Design Development**	**92 days**	**Mon 5/20/19**	**Mon 9/30/19**
19	**Construction Set / Permit**	**141 days**	**Mon 8/26/19**	**Tue 3/17/20**
39	**Financial Closing**	**77 days**	**Thu 1/30/20**	**Fri 5/15/20**
40	Financial Closing	57 days	Thu 1/30/20	Fri 4/17/20
41	OHCS - Delay to mid April	15 days	Fri 4/3/20	Thu 4/23/20
42	GMP Amendment Executed	1 day	Mon 4/20/20	Mon 4/20/20
43	Subcontracts to Subs/ Suppliers	10 days	Mon 4/13/20	Fri 4/24/20
44	Appraisal	18 days	Tue 4/21/20	Thu 5/14/20
45	Notice to Proceed	1 day	Fri 5/15/20	Fri 5/15/20
46	**Construction**	**651 days**	**Tue 1/15/19**	**Mon 8/9/21**
47	**Submittals**	**619 days**	**Tue 2/5/19**	**Fri 7/16/21**
446	**Alternates**	**630 days**	**Tue 1/15/19**	**Mon 7/12/21**
588	**Mobilization**	**285 days**	**Thu 3/12/20**	**Mon 4/26/21**
589	Postmaster approval of temp mailbox shed	15 days	Fri 3/27/20	Fri 4/17/20
590	Approve County IT temporary plan	25 days	Thu 3/12/20	Wed 4/15/20
591	County schedule IT work	10 days	Thu 4/16/20	Wed 4/29/20
592	County relocate level 1 IT equipment	2 days	Thu 4/30/20	Fri 5/1/20
593	Rock pad for trailers and mailbox	1 day	Fri 4/17/20	Fri 4/17/20
594	Deliver trailers and mailbox shed	1 day	Tue 4/21/20	Tue 4/21/20
595	Build mailbox shed	3 days	Wed 4/22/20	Fri 4/24/20
596	Building temp office power and IT and furniture	5 days	Mon 5/4/20	Fri 5/8/20
597	Resident Services moves into temporary office trailer	2 days	Mon 5/11/20	Tue 5/12/20
598	Conex for Building Maintenance storage Deliver/Fill	5 days	Mon 5/4/20	Fri 5/8/20
599	Move mailboxes into temporary shed	1 day	Mon 5/4/20	Mon 5/4/20
600	Property Mgmt moves into temporary office trailer	2 days	Fri 4/23/21	Mon 4/26/21
601	**Site Preconstruction Meetings**	**1 day**	**Tue 4/9/19**	**Tue 4/9/19**
616	**RDH Visits**	**259 days**	**Mon 6/15/20**	**Tue 6/22/21**
617	Duct penetrations East and West	1 day	Mon 6/15/20	Mon 6/15/20
618	Roof coating and flashing	1 day	Thu 7/2/20	Thu 7/2/20
619	Level 2 entry storefront	1 day	Tue 6/22/21	Tue 6/22/21
620	**Building / Site**	**311 days**	**Mon 5/18/20**	**Mon 8/9/21**
621	**Ground Floor- Seismic Upgrade**	**179 days**	**Mon 5/18/20**	**Tue 2/2/21**



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

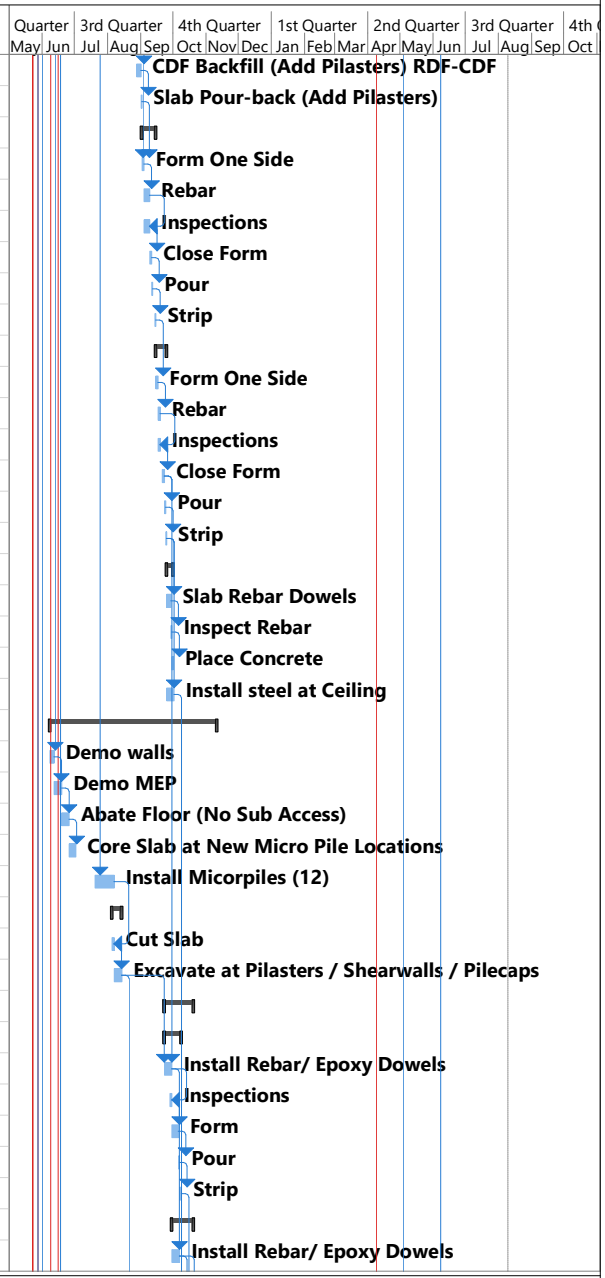
ID	Task Name	Duration	Start	Finish
622	Owner moves FFE out of space	3 days	Mon 5/18/20	Wed 5/20/20
623	Safe-Off Fire Sprinkler System	1 day	Wed 5/20/20	Wed 5/20/20
624	Demo ceiling throughout	2 days	Thu 5/21/20	Fri 5/22/20
625	Plumbing/Electrical/ HVAC - Temporary Configuration of systems in co	2 wks	Tue 5/26/20	Mon 6/8/20
626	Shoring/Bracing MEP As needed	1 wk	Tue 5/26/20	Mon 6/1/20
627	**East Wing**	**86 days**	**Tue 6/2/20**	**Thu 10/1/20**
628	Demo walls	4 days	Tue 6/2/20	Fri 6/5/20
629	Demo MEP	3 days	Mon 6/8/20	Wed 6/10/20
630	Abate Floor (No Sub Access)	7 days	Thu 6/11/20	Fri 6/19/20
631	Core Slab at New Micro Pile Locations	4 days	Mon 6/22/20	Thu 6/25/20
632	Install Micorpiles (16)	18 days	Tue 6/23/20	Fri 7/17/20
633	**Grid 6 Steel plates**	**13 days**	**Fri 6/26/20**	**Wed 7/15/20**
634	Map existing rebar	1 day	Fri 6/26/20	Fri 6/26/20
635	Core wall for through bolts	3 days	Mon 6/29/20	Wed 7/1/20
636	Install east side steel and bolt	3 days	Thu 7/2/20	Tue 7/7/20
637	Grout bolts	3 days	Wed 7/8/20	Fri 7/10/20
638	Install west side steel and nut	3 days	Mon 7/13/20	Wed 7/15/20
639	**Slab demo at Concrete Pilasters / Center Shearwalls**	**9 days**	**Thu 7/16/20**	**Tue 7/28/20**
640	Cut Slab	2 days	Thu 7/16/20	Fri 7/17/20
641	Excavate at Pilasters / Shearwalls	7 days	Mon 7/20/20	Tue 7/28/20
642	**Concrete Pilasters (16)**	**20 days**	**Mon 7/27/20**	**Fri 8/21/20**
643	**Pilasters Grid 7**	**13 days**	**Mon 7/27/20**	**Wed 8/12/20**
644	Install Rebar/ Epoxy Dowels	6 days	Mon 7/27/20	Mon 8/3/20
645	Inspections	2 days	Fri 7/31/20	Mon 8/3/20
646	Form	4 days	Tue 8/4/20	Fri 8/7/20
647	Pour (ABHT Site visit to verify concrete flow)	1 day	Mon 8/10/20	Mon 8/10/20
648	Strip	2 days	Tue 8/11/20	Wed 8/12/20
649	**Pilasters Grid 6**	**14 days**	**Tue 8/4/20**	**Fri 8/21/20**
650	Install Rebar/ Epoxy Dowels	6 days	Tue 8/4/20	Tue 8/11/20
651	Inspections	2 days	Mon 8/10/20	Tue 8/11/20
652	Form	4 days	Thu 8/13/20	Tue 8/18/20
653	Pour	1 day	Wed 8/19/20	Wed 8/19/20
654	Strip	2 days	Thu 8/20/20	Fri 8/21/20
655	**Central Concrete Shearwalls**	**26 days**	**Wed 8/19/20**	**Thu 9/24/20**
656	**Footing**	**10 days**	**Wed 8/19/20**	**Tue 9/1/20**
657	Form, Rebar, Dowel	5 days	Wed 8/19/20	Tue 8/25/20
658	Inspections	2 days	Mon 8/24/20	Tue 8/25/20
659	Pour	1 day	Wed 8/26/20	Wed 8/26/20
660	Strip	1 day	Thu 8/27/20	Thu 8/27/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

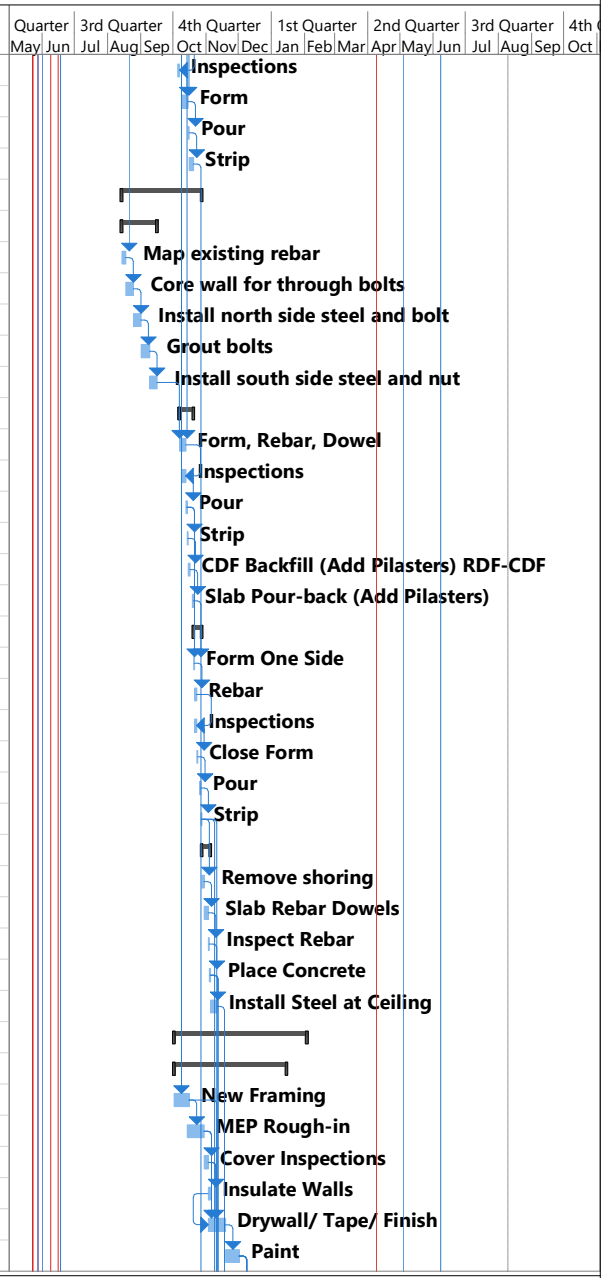
ID	Task Name	Duration	Start	Finish
661	CDF Backfill (Add Pilasters) RDF-CDF	2 days	Fri 8/28/20	Mon 8/31/20
662	Slab Pour-back (Add Pilasters)	1 day	Tue 9/1/20	Tue 9/1/20
663	**North Wall and North Column Wrap**	**8 days**	**Wed 9/2/20**	**Mon 9/14/20**
664	Form One Side	2 days	Wed 9/2/20	Thu 9/3/20
665	Rebar	2 days	Fri 9/4/20	Tue 9/8/20
666	Inspections	2 days	Fri 9/4/20	Tue 9/8/20
667	Close Form	2 days	Wed 9/9/20	Thu 9/10/20
668	Pour	1 day	Fri 9/11/20	Fri 9/11/20
669	Strip	1 day	Mon 9/14/20	Mon 9/14/20
670	**South Wall and South Column Wrap**	**8 days**	**Tue 9/15/20**	**Thu 9/24/20**
671	Form One Side	2 days	Tue 9/15/20	Wed 9/16/20
672	Rebar	2 days	Thu 9/17/20	Fri 9/18/20
673	Inspections	2 days	Thu 9/17/20	Fri 9/18/20
674	Close Form	2 days	Mon 9/21/20	Tue 9/22/20
675	Pour	1 day	Wed 9/23/20	Wed 9/23/20
676	Strip	1 day	Thu 9/24/20	Thu 9/24/20
677	**Slab On Grade**	**4 days**	**Fri 9/25/20**	**Wed 9/30/20**
678	Slab Rebar Dowels	2 days	Fri 9/25/20	Mon 9/28/20
679	Inspect Rebar	1 day	Tue 9/29/20	Tue 9/29/20
680	Place Concrete	1 day	Wed 9/30/20	Wed 9/30/20
681	Install steel at Ceiling	5 days	Fri 9/25/20	Thu 10/1/20
682	**West Wing**	**110 days**	**Mon 6/8/20**	**Tue 11/10/20**
683	Demo walls	4 days	Mon 6/8/20	Thu 6/11/20
684	Demo MEP	5 days	Fri 6/12/20	Thu 6/18/20
685	Abate Floor (No Sub Access)	5 days	Fri 6/19/20	Thu 6/25/20
686	Core Slab at New Micro Pile Locations	4 days	Fri 6/26/20	Wed 7/1/20
687	Install Micorpiles (12)	14 days	Mon 7/20/20	Thu 8/6/20
688	**Slab demo at Concrete Pilasters / Center Shearwalls**	**7 days**	**Wed 8/5/20**	**Thu 8/13/20**
689	Cut Slab	2 days	Wed 8/5/20	Thu 8/6/20
690	Excavate at Pilasters / Shearwalls / Pilecaps	5 days	Fri 8/7/20	Thu 8/13/20
691	**Concrete Pilasters (16)**	**19 days**	**Wed 9/23/20**	**Mon 10/19/20**
692	**Pilasters Grid 4 and Column Wraps (2)**	**12 days**	**Wed 9/23/20**	**Thu 10/8/20**
693	Install Rebar/ Epoxy Dowels	5 days	Wed 9/23/20	Tue 9/29/20
694	Inspections	2 days	Mon 9/28/20	Tue 9/29/20
695	Form	4 days	Wed 9/30/20	Mon 10/5/20
696	Pour	1 day	Tue 10/6/20	Tue 10/6/20
697	Strip	2 days	Wed 10/7/20	Thu 10/8/20
698	**Pilasters Grid 1 and 2**	**14 days**	**Wed 9/30/20**	**Mon 10/19/20**
699	Install Rebar/ Epoxy Dowels	5 days	Wed 9/30/20	Tue 10/6/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

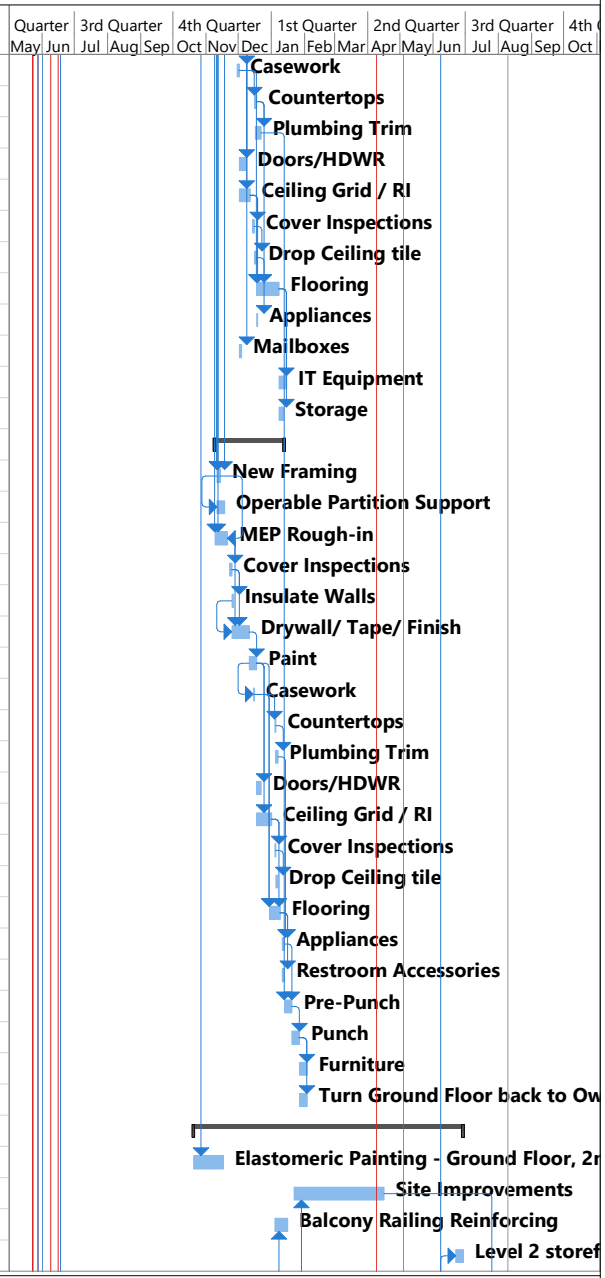
ID	Task Name	Duration	Start	Finish
700	Inspections	2 days	Mon 10/5/20	Tue 10/6/20
701	Form	4 days	Fri 10/9/20	Wed 10/14/20
702	Pour	1 day	Thu 10/15/20	Thu 10/15/20
703	Strip	2 days	Fri 10/16/20	Mon 10/19/20
704	**Central Concrete Shearwalls**	**52 days**	**Fri 8/14/20**	**Tue 10/27/20**
705	**Grid F Steel plates**	**22 days**	**Fri 8/14/20**	**Tue 9/15/20**
706	Map existing rebar	2 days	Fri 8/14/20	Mon 8/17/20
707	Core wall for through bolts	5 days	Tue 8/18/20	Mon 8/24/20
708	Install north side steel and bolt	5 days	Tue 8/25/20	Mon 8/31/20
709	Grout bolts	5 days	Tue 9/1/20	Tue 9/8/20
710	Install south side steel and nut	5 days	Wed 9/9/20	Tue 9/15/20
711	**Footings**	**9 days**	**Wed 10/7/20**	**Mon 10/19/20**
712	Form, Rebar, Dowel	4 days	Wed 10/7/20	Mon 10/12/20
713	Inspections	2 days	Fri 10/9/20	Mon 10/12/20
714	Pour	1 day	Tue 10/13/20	Tue 10/13/20
715	Strip	1 day	Wed 10/14/20	Wed 10/14/20
716	CDF Backfill (Add Pilasters) RDF-CDF	2 days	Thu 10/15/20	Fri 10/16/20
717	Slab Pour-back (Add Pilasters)	1 day	Mon 10/19/20	Mon 10/19/20
718	**Wall**	**6 days**	**Tue 10/20/20**	**Tue 10/27/20**
719	Form One Side	1 day	Tue 10/20/20	Tue 10/20/20
720	Rebar	2 days	Wed 10/21/20	Thu 10/22/20
721	Inspections	2 days	Wed 10/21/20	Thu 10/22/20
722	Close Form	1 day	Fri 10/23/20	Fri 10/23/20
723	Pour	1 day	Mon 10/26/20	Mon 10/26/20
724	Strip	1 day	Tue 10/27/20	Tue 10/27/20
725	**Slab On Grade**	**6 days**	**Wed 10/28/20**	**Wed 11/4/20**
726	Remove shoring	2 days	Wed 10/28/20	Thu 10/29/20
727	Slab Rebar Dowels	2 days	Fri 10/30/20	Mon 11/2/20
728	Inspect Rebar	1 day	Tue 11/3/20	Tue 11/3/20
729	Place Concrete	1 day	Wed 11/4/20	Wed 11/4/20
730	Install Steel at Ceiling	4 days	Thu 11/5/20	Tue 11/10/20
731	**Ground Floor Rough-in to Finish**	**83 days**	**Fri 10/2/20**	**Tue 2/2/21**
732	**East**	**70 days**	**Fri 10/2/20**	**Thu 1/14/21**
733	New Framing	10 days	Fri 10/2/20	Thu 10/15/20
734	MEP Rough-in	12 days	Wed 10/14/20	Thu 10/29/20
735	Cover Inspections	2 days	Fri 10/30/20	Mon 11/2/20
736	Insulate Walls	2 days	Tue 11/3/20	Wed 11/4/20
737	Drywall/ Tape/ Finish	12 days	Tue 11/3/20	Wed 11/18/20
738	Paint	7 days	Thu 11/19/20	Tue 12/1/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

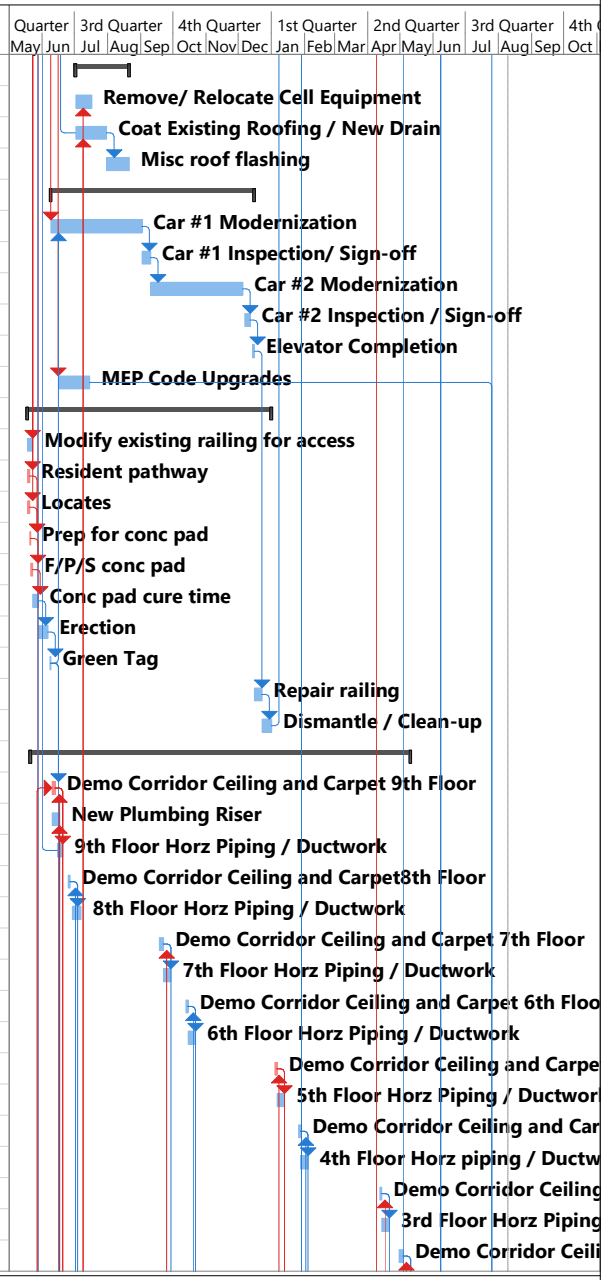
ID	Task Name	Duration	Start	Finish
739	Casework	2 days	Mon 11/30/20	Tue 12/1/20
740	Countertops	2 days	Wed 12/16/20	Thu 12/17/20
741	Plumbing Trim	3 days	Thu 12/17/20	Mon 12/21/20
742	Doors/HDWR	4 days	Wed 12/2/20	Mon 12/7/20
743	Ceiling Grid / RI	8 days	Wed 12/2/20	Fri 12/11/20
744	Cover Inspections	2 days	Mon 12/14/20	Tue 12/15/20
745	Drop Ceiling tile	2 days	Wed 12/16/20	Thu 12/17/20
746	Flooring	12 days	Fri 12/18/20	Thu 1/7/21
747	Appliances	1 day	Fri 12/18/20	Fri 12/18/20
748	Mailboxes	2 days	Wed 12/2/20	Thu 12/3/20
749	IT Equipment	5 days	Fri 1/8/21	Thu 1/14/21
750	Storage	2 days	Fri 1/8/21	Mon 1/11/21
751	**West**	**42 days**	**Mon 11/9/20**	**Tue 1/12/21**
752	New Framing	3 days	Wed 11/11/20	Fri 11/13/20
753	Operable Partition Support	5 days	Wed 11/11/20	Tue 11/17/20
754	MEP Rough-in	10 days	Mon 11/9/20	Fri 11/20/20
755	Cover Inspections	2 days	Mon 11/23/20	Tue 11/24/20
756	Insulate Walls	1 day	Wed 11/25/20	Wed 11/25/20
757	Drywall/ Tape/ Finish	10 days	Wed 11/25/20	Thu 12/10/20
758	Paint	5 days	Fri 12/11/20	Thu 12/17/20
759	Casework	1 day	Tue 12/15/20	Tue 12/15/20
760	Countertops	1 day	Mon 1/4/21	Mon 1/4/21
761	Plumbing Trim	2 days	Tue 1/5/21	Wed 1/6/21
762	Doors/HDWR	2 days	Fri 12/18/20	Mon 12/21/20
763	Ceiling Grid / RI	8 days	Fri 12/18/20	Thu 12/31/20
764	Cover Inspections	1 day	Mon 1/4/21	Mon 1/4/21
765	Drop Ceiling tile	1 day	Tue 1/5/21	Tue 1/5/21
766	Flooring	7 days	Wed 12/30/20	Fri 1/8/21
767	Appliances	2 days	Mon 1/11/21	Tue 1/12/21
768	Restroom Accessories	2 days	Mon 1/11/21	Tue 1/12/21
769	Pre-Punch	5 days	Wed 1/13/21	Tue 1/19/21
770	Punch	5 days	Wed 1/20/21	Tue 1/26/21
771	Furniture	5 days	Wed 1/27/21	Tue 2/2/21
772	Turn Ground Floor back to Owner/Residents	5 days	Wed 1/27/21	Tue 2/2/21
773	**Exterior**	**174 days**	**Tue 10/20/20**	**Mon 6/28/21**
774	Elastomeric Painting - Ground Floor, 2nd Floor	20 days	Tue 10/20/20	Mon 11/16/20
775	Site Improvements	12 wks	Fri 1/22/21	Thu 4/15/21
776	Balcony Railing Reinforcing	10 days	Mon 1/4/21	Fri 1/15/21
777	Level 2 storefront	5 days	Tue 6/22/21	Mon 6/28/21



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

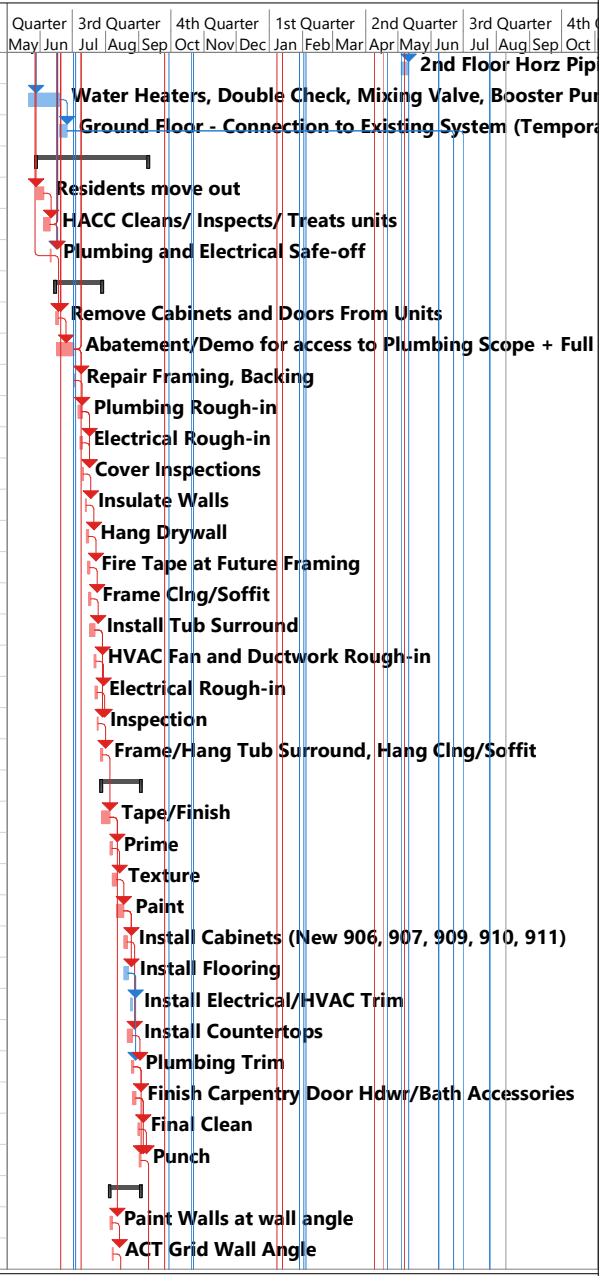
ID	Task Name	Duration	Start	Finish
778	**Roofing**	**35 days**	**Thu 7/2/20**	**Thu 8/20/20**
779	Remove/ Relocate Cell Equipment	10 days	Thu 7/2/20	Thu 7/16/20
780	Coat Existing Roofing / New Drain	20 days	Thu 7/2/20	Thu 7/30/20
781	Misc roof flashing	15 days	Fri 7/31/20	Thu 8/20/20
782	**Elevator Modernization**	**132 days**	**Tue 6/9/20**	**Tue 12/15/20**
783	Car #1 Modernization	12 wks	Tue 6/9/20	Tue 9/1/20
784	Car #1 Inspection/ Sign-off	1 wk	Wed 9/2/20	Wed 9/9/20
785	Car #2 Modernization	12 wks	Thu 9/10/20	Fri 12/4/20
786	Car #2 Inspection / Sign-off	1 wk	Mon 12/7/20	Fri 12/11/20
787	Elevator Completion	2 days	Mon 12/14/20	Tue 12/15/20
788	MEP Code Upgrades	20 days	Tue 6/16/20	Tue 7/14/20
789	**Man - Material Hoist**	**157 days**	**Mon 5/18/20**	**Thu 12/31/20**
790	Modify existing railing for access	5 days	Mon 5/18/20	Fri 5/22/20
791	Resident pathway	2 days	Mon 5/18/20	Tue 5/19/20
792	Locates	2 days	Mon 5/18/20	Tue 5/19/20
793	Prep for conc pad	1 day	Wed 5/20/20	Wed 5/20/20
794	F/P/S conc pad	2 days	Thu 5/21/20	Fri 5/22/20
795	Conc pad cure time	5 edays	Fri 5/22/20	Wed 5/27/20
796	Erection	7 days	Thu 5/28/20	Fri 6/5/20
797	Green Tag	1 day	Mon 6/8/20	Mon 6/8/20
798	Repair railing	5 days	Wed 12/16/20	Tue 12/22/20
799	Dismantle / Clean-up	5 days	Wed 12/23/20	Thu 12/31/20
800	**Plumbing / Ductwork Rough-in**	**245 days**	**Thu 5/21/20**	**Mon 5/10/21**
801	Demo Corridor Ceiling and Carpet 9th Floor	3 days	Wed 6/10/20	Fri 6/12/20
802	New Plumbing Riser	5 days	Wed 6/10/20	Tue 6/16/20
803	9th Floor Horz Piping / Ductwork	5 days	Mon 6/15/20	Fri 6/19/20
804	Demo Corridor Ceiling and Carpet8th Floor	2 days	Thu 6/25/20	Fri 6/26/20
805	8th Floor Horz Piping / Ductwork	5 days	Mon 6/29/20	Mon 7/6/20
806	Demo Corridor Ceiling and Carpet 7th Floor	2 days	Fri 9/18/20	Mon 9/21/20
807	7th Floor Horz Piping / Ductwork	5 days	Tue 9/22/20	Mon 9/28/20
808	Demo Corridor Ceiling and Carpet 6th Floor	2 days	Tue 10/13/20	Wed 10/14/20
809	6th Floor Horz Piping / Ductwork	5 days	Thu 10/15/20	Wed 10/21/20
810	Demo Corridor Ceiling and Carpet 5th Floor	2 days	Mon 1/4/21	Tue 1/5/21
811	5th Floor Horz Piping / Ductwork	5 days	Wed 1/6/21	Tue 1/12/21
812	Demo Corridor Ceiling and Carpet4th Floor	2 days	Tue 1/26/21	Wed 1/27/21
813	4th Floor Horz piping / Ductwork	5 days	Thu 1/28/21	Wed 2/3/21
814	Demo Corridor Ceiling and Carpet3rd Floor	2 days	Mon 4/12/21	Tue 4/13/21
815	3rd Floor Horz Piping / Ductwork	5 days	Wed 4/14/21	Tue 4/20/21
816	Demo Corridor Ceiling and Carpet 2nd Floor	2 days	Fri 4/30/21	Mon 5/3/21



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

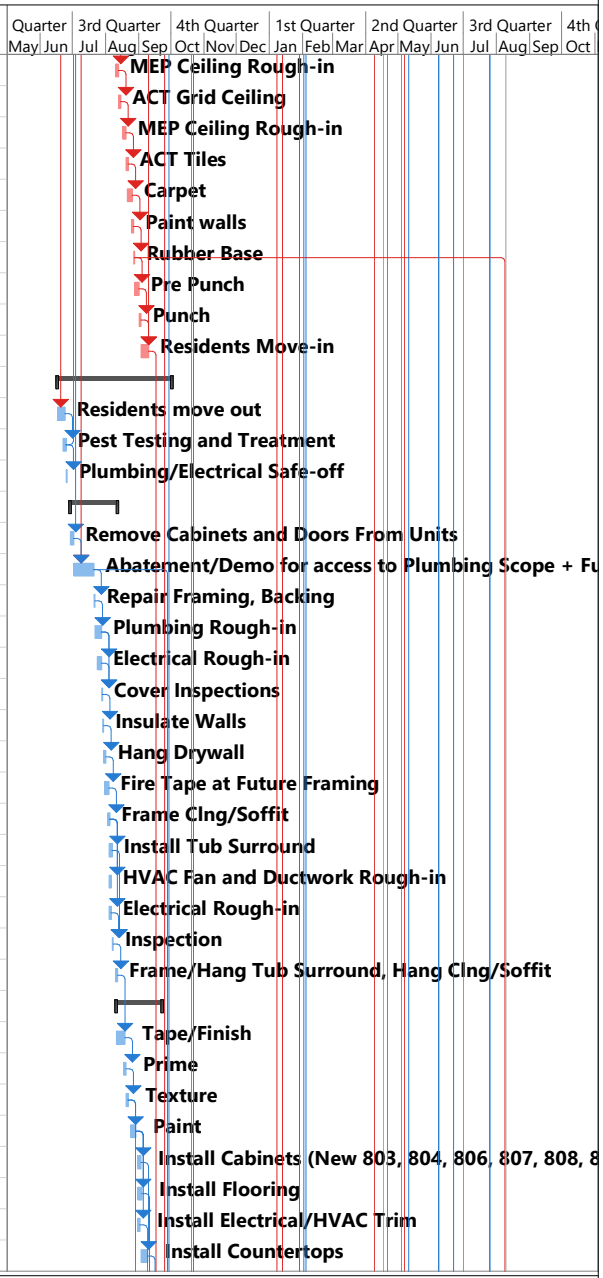
ID	Task Name	Duration	Start	Finish
817	2nd Floor Horz Piping / Ductwork	5 days	Tue 5/4/21	Mon 5/10/21
818	Water Heaters, Double Check, Mixing Valve, Booster Pump	20 days	Thu 5/21/20	Thu 6/18/20
819	Ground Floor - Connection to Existing System (Temporary)	5 days	Fri 6/19/20	Thu 6/25/20
820	**Level 9 (13 units)**	**73 days**	**Thu 5/28/20**	**Wed 9/9/20**
821	Residents move out	5 days	Thu 5/28/20	Wed 6/3/20
822	HACC Cleans/ Inspects/ Treats units	4 days	Thu 6/4/20	Tue 6/9/20
823	Plumbing and Electrical Safe-off	1 day	Wed 6/10/20	Wed 6/10/20
824	**Demo and Rough-in**	**31 days**	**Mon 6/15/20**	**Tue 7/28/20**
825	Remove Cabinets and Doors From Units	3 days	Mon 6/15/20	Wed 6/17/20
826	Abatement/Demo for access to Plumbing Scope + Full Ceiling Abater	12 days	Tue 6/16/20	Wed 7/1/20
827	Repair Framing, Backing	1 day	Thu 7/2/20	Thu 7/2/20
828	Plumbing Rough-in	4 days	Mon 7/6/20	Thu 7/9/20
829	Electrical Rough-in	2 days	Wed 7/8/20	Thu 7/9/20
830	Cover Inspections	1 day	Fri 7/10/20	Fri 7/10/20
831	Insulate Walls	1 day	Mon 7/13/20	Mon 7/13/20
832	Hang Drywall	2 days	Tue 7/14/20	Wed 7/15/20
833	Fire Tape at Future Framing	2 days	Wed 7/15/20	Thu 7/16/20
834	Frame Clng/Soffit	2 days	Thu 7/16/20	Fri 7/17/20
835	Install Tub Surround	3 days	Fri 7/17/20	Tue 7/21/20
836	HVAC Fan and Ductwork Rough-in	2 days	Tue 7/21/20	Wed 7/22/20
837	Electrical Rough-in	2 days	Wed 7/22/20	Thu 7/23/20
838	Inspection	1 day	Fri 7/24/20	Fri 7/24/20
839	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Mon 7/27/20	Tue 7/28/20
840	**Finishes**	**27 days**	**Tue 7/28/20**	**Wed 9/2/20**
841	Tape/Finish	6 days	Tue 7/28/20	Tue 8/4/20
842	Prime	2 days	Wed 8/5/20	Thu 8/6/20
843	Texture	2 days	Fri 8/7/20	Mon 8/10/20
844	Paint	5 days	Tue 8/11/20	Mon 8/17/20
845	Install Cabinets (New 906, 907, 909, 910, 911)	3 days	Tue 8/18/20	Thu 8/20/20
846	Install Flooring	4 days	Tue 8/18/20	Fri 8/21/20
847	Install Electrical/HVAC Trim	2 days	Mon 8/24/20	Tue 8/25/20
848	Install Countertops	3 days	Fri 8/21/20	Tue 8/25/20
849	Plumbing Trim	2 days	Tue 8/25/20	Wed 8/26/20
850	Finish Carpentry Door Hdwr/Bath Accessories	3 days	Wed 8/26/20	Fri 8/28/20
851	Final Clean	1 day	Mon 8/31/20	Mon 8/31/20
852	Punch	2 days	Tue 9/1/20	Wed 9/2/20
853	**Corridor Finishes**	**21 days**	**Wed 8/5/20**	**Wed 9/2/20**
854	Paint Walls at wall angle	2 days	Wed 8/5/20	Thu 8/6/20
855	ACT Grid Wall Angle	1 day	Fri 8/7/20	Fri 8/7/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

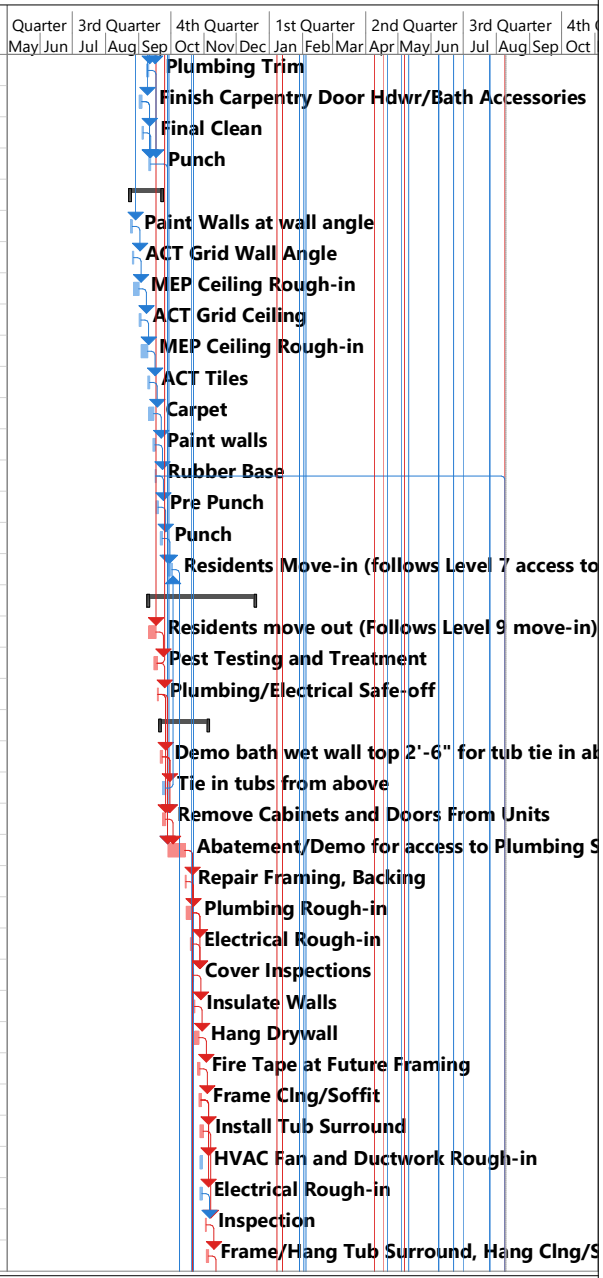
ID	Task Name	Duration	Start	Finish
856	MEP Ceiling Rough-in	3 days	Mon 8/10/20	Wed 8/12/20
857	ACT Grid Ceiling	2 days	Thu 8/13/20	Fri 8/14/20
858	MEP Ceiling Rough-in	3 days	Mon 8/17/20	Wed 8/19/20
859	ACT Tiles	2 days	Thu 8/20/20	Fri 8/21/20
860	Carpet	3 days	Fri 8/21/20	Tue 8/25/20
861	Paint walls	2 days	Tue 8/25/20	Wed 8/26/20
862	Rubber Base	1 day	Thu 8/27/20	Thu 8/27/20
863	Pre Punch	2 days	Fri 8/28/20	Mon 8/31/20
864	Punch	2 days	Tue 9/1/20	Wed 9/2/20
865	Residents Move-in	4 days	Thu 9/3/20	Wed 9/9/20
866	**Level 8 (13 units)**	**75 days**	**Wed 6/17/20**	**Thu 10/1/20**
867	Residents move out	5 days	Wed 6/17/20	Tue 6/23/20
868	Pest Testing and Treatment	3 days	Mon 6/22/20	Wed 6/24/20
869	Plumbing/Electrical Safe-off	1 day	Thu 6/25/20	Thu 6/25/20
870	**Demo and Rough-in**	**31 days**	**Mon 6/29/20**	**Tue 8/11/20**
871	Remove Cabinets and Doors From Units	3 days	Mon 6/29/20	Wed 7/1/20
872	Abatement/Demo for access to Plumbing Scope + Full Ceiling Abater	12 days	Thu 7/2/20	Mon 7/20/20
873	Repair Framing, Backing	1 day	Tue 7/21/20	Tue 7/21/20
874	Plumbing Rough-in	4 days	Wed 7/22/20	Mon 7/27/20
875	Electrical Rough-in	2 days	Fri 7/24/20	Mon 7/27/20
876	Cover Inspections	1 day	Tue 7/28/20	Tue 7/28/20
877	Insulate Walls	1 day	Wed 7/29/20	Wed 7/29/20
878	Hang Drywall	2 days	Thu 7/30/20	Fri 7/31/20
879	Fire Tape at Future Framing	2 days	Fri 7/31/20	Mon 8/3/20
880	Frame Clng/Soffit	2 days	Mon 8/3/20	Tue 8/4/20
881	Install Tub Surround	3 days	Tue 8/4/20	Thu 8/6/20
882	HVAC Fan and Ductwork Rough-in	2 days	Tue 8/4/20	Wed 8/5/20
883	Electrical Rough-in	2 days	Tue 8/4/20	Wed 8/5/20
884	Inspection	1 day	Fri 8/7/20	Fri 8/7/20
885	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Mon 8/10/20	Tue 8/11/20
886	**Finishes**	**30 days**	**Tue 8/11/20**	**Tue 9/22/20**
887	Tape/Finish	6 days	Tue 8/11/20	Tue 8/18/20
888	Prime	2 days	Tue 8/18/20	Wed 8/19/20
889	Texture	2 days	Thu 8/20/20	Fri 8/21/20
890	Paint	5 days	Mon 8/24/20	Fri 8/28/20
891	Install Cabinets (New 803, 804, 806, 807, 808, 812, 813)	3 days	Mon 8/31/20	Wed 9/2/20
892	Install Flooring	4 days	Mon 8/31/20	Thu 9/3/20
893	Install Electrical/HVAC Trim	2 days	Mon 8/31/20	Tue 9/1/20
894	Install Countertops	3 days	Thu 9/3/20	Tue 9/8/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

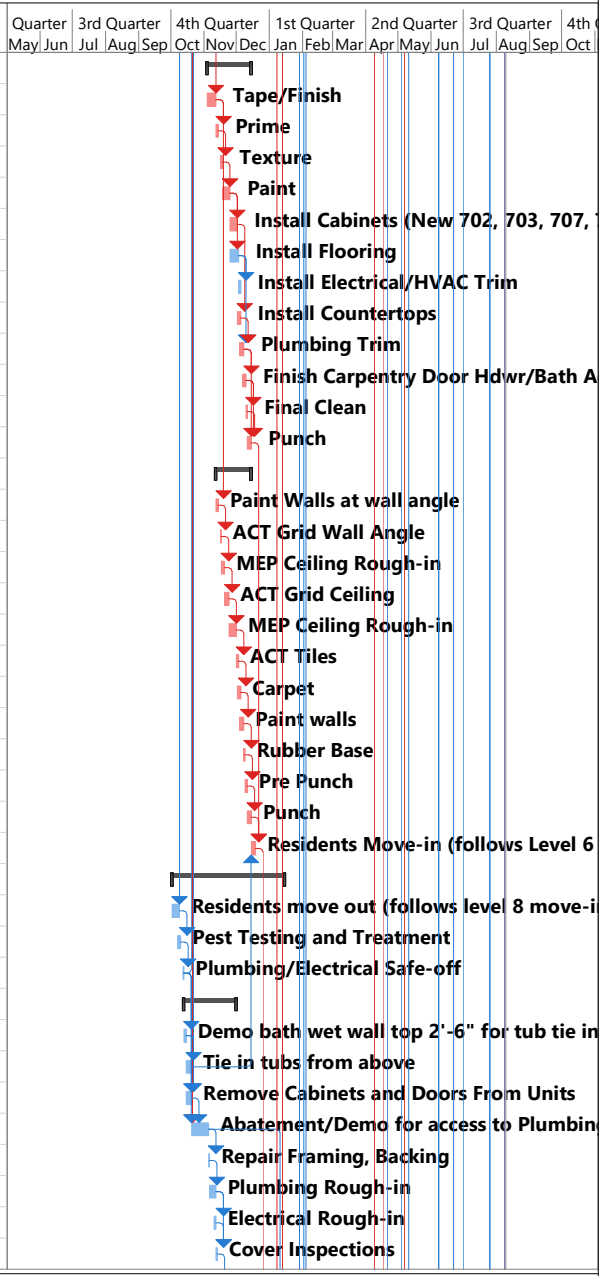
ID	Task Name	Duration	Start	Finish
895	Plumbing Trim	2 days	Tue 9/8/20	Wed 9/9/20
896	Finish Carpentry Door Hdwr/Bath Accessories	3 days	Tue 9/1/20	Thu 9/3/20
897	Final Clean	1 day	Fri 9/4/20	Fri 9/4/20
898	Punch	2 days	Thu 9/10/20	Fri 9/11/20
899	**Corridor Finishes**	**21 days**	**Mon 8/24/20**	**Tue 9/22/20**
900	Paint Walls at wall angle	2 days	Mon 8/24/20	Tue 8/25/20
901	ACT Grid Wall Angle	1 day	Wed 8/26/20	Wed 8/26/20
902	MEP Ceiling Rough-in	3 days	Thu 8/27/20	Mon 8/31/20
903	ACT Grid Ceiling	2 days	Tue 9/1/20	Wed 9/2/20
904	MEP Ceiling Rough-in	3 days	Thu 9/3/20	Tue 9/8/20
905	ACT Tiles	2 days	Wed 9/9/20	Thu 9/10/20
906	Carpet	3 days	Thu 9/10/20	Mon 9/14/20
907	Paint walls	2 days	Mon 9/14/20	Tue 9/15/20
908	Rubber Base	1 day	Wed 9/16/20	Wed 9/16/20
909	Pre Punch	2 days	Thu 9/17/20	Fri 9/18/20
910	Punch	2 days	Mon 9/21/20	Tue 9/22/20
911	Residents Move-in (follows Level 7 access to level 8 tub tie-in)	4 days	Mon 9/28/20	Thu 10/1/20
912	**Level 7 (13 units)**	**70 days**	**Thu 9/10/20**	**Fri 12/18/20**
913	Residents move out (Follows Level 9 move-in)	5 days	Thu 9/10/20	Wed 9/16/20
914	Pest Testing and Treatment	3 days	Tue 9/15/20	Thu 9/17/20
915	Plumbing/Electrical Safe-off	1 day	Fri 9/18/20	Fri 9/18/20
916	**Demo and Rough-in**	**33 days**	**Mon 9/21/20**	**Wed 11/4/20**
917	Demo bath wet wall top 2'-6" for tub tie in above	2 days	Mon 9/21/20	Tue 9/22/20
918	Tie in tubs from above	3 days	Wed 9/23/20	Fri 9/25/20
919	Remove Cabinets and Doors From Units	3 days	Wed 9/23/20	Fri 9/25/20
920	Abatement/Demo for access to Plumbing Scope + Full Ceiling Abater	12 days	Mon 9/28/20	Tue 10/13/20
921	Repair Framing, Backing	1 day	Wed 10/14/20	Wed 10/14/20
922	Plumbing Rough-in	4 days	Thu 10/15/20	Tue 10/20/20
923	Electrical Rough-in	2 days	Mon 10/19/20	Tue 10/20/20
924	Cover Inspections	1 day	Wed 10/21/20	Wed 10/21/20
925	Insulate Walls	1 day	Thu 10/22/20	Thu 10/22/20
926	Hang Drywall	2 days	Fri 10/23/20	Mon 10/26/20
927	Fire Tape at Future Framing	2 days	Mon 10/26/20	Tue 10/27/20
928	Frame Clng/Soffit	2 days	Tue 10/27/20	Wed 10/28/20
929	Install Tub Surround	3 days	Wed 10/28/20	Fri 10/30/20
930	HVAC Fan and Ductwork Rough-in	2 days	Wed 10/28/20	Thu 10/29/20
931	Electrical Rough-in	2 days	Wed 10/28/20	Thu 10/29/20
932	Inspection	1 day	Mon 11/2/20	Mon 11/2/20
933	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Tue 11/3/20	Wed 11/4/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

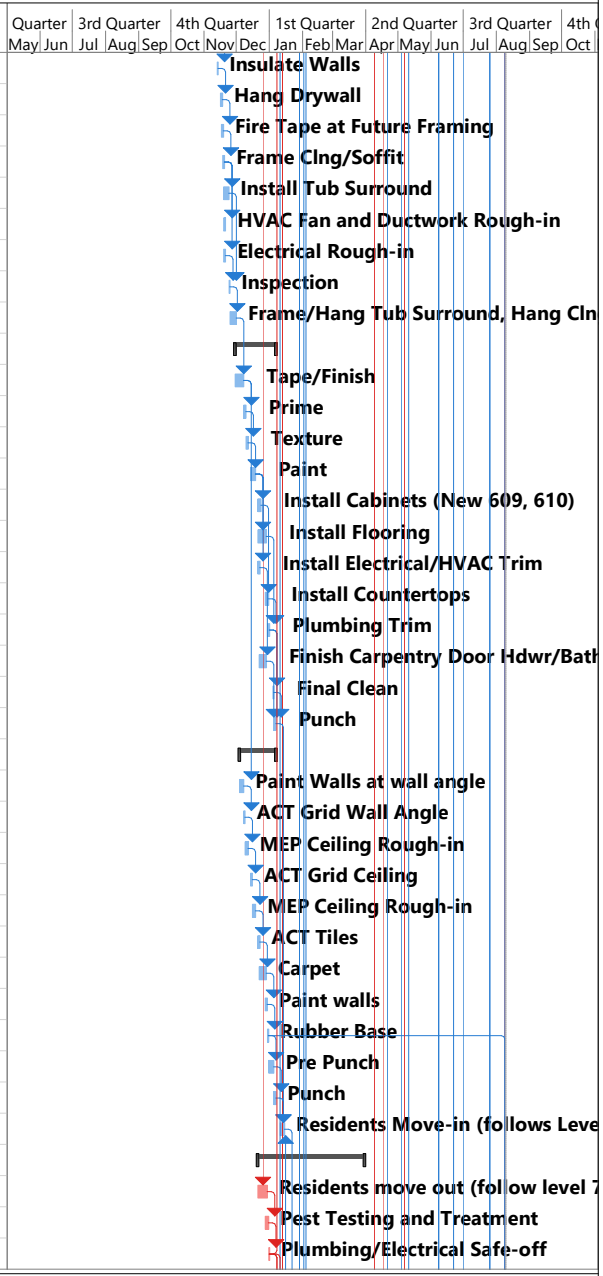
ID	Task Name	Duration	Start	Finish
934	**Finishes**	**27 days**	**Wed 11/4/20**	**Mon 12/14/20**
935	Tape/Finish	6 days	Wed 11/4/20	Wed 11/11/20
936	Prime	2 days	Thu 11/12/20	Fri 11/13/20
937	Texture	2 days	Mon 11/16/20	Tue 11/17/20
938	Paint	5 days	Wed 11/18/20	Tue 11/24/20
939	Install Cabinets (New 702, 703, 707, 708)	3 days	Wed 11/25/20	Tue 12/1/20
940	Install Flooring	4 days	Wed 11/25/20	Wed 12/2/20
941	Install Electrical/HVAC Trim	2 days	Thu 12/3/20	Fri 12/4/20
942	Install Countertops	3 days	Wed 12/2/20	Fri 12/4/20
943	Plumbing Trim	2 days	Fri 12/4/20	Mon 12/7/20
944	Finish Carpentry Door Hdwr/Bath Accessories	3 days	Mon 12/7/20	Wed 12/9/20
945	Final Clean	1 day	Thu 12/10/20	Thu 12/10/20
946	Punch	2 days	Fri 12/11/20	Mon 12/14/20
947	**Corridor Finishes**	**21 days**	**Thu 11/12/20**	**Mon 12/14/20**
948	Paint Walls at wall angle	2 days	Thu 11/12/20	Fri 11/13/20
949	ACT Grid Wall Angle	1 day	Mon 11/16/20	Mon 11/16/20
950	MEP Ceiling Rough-in	3 days	Tue 11/17/20	Thu 11/19/20
951	ACT Grid Ceiling	2 days	Fri 11/20/20	Mon 11/23/20
952	MEP Ceiling Rough-in	3 days	Tue 11/24/20	Mon 11/30/20
953	ACT Tiles	2 days	Tue 12/1/20	Wed 12/2/20
954	Carpet	3 days	Wed 12/2/20	Fri 12/4/20
955	Paint walls	2 days	Fri 12/4/20	Mon 12/7/20
956	Rubber Base	1 day	Tue 12/8/20	Tue 12/8/20
957	Pre Punch	2 days	Wed 12/9/20	Thu 12/10/20
958	Punch	2 days	Fri 12/11/20	Mon 12/14/20
959	Residents Move-in (follows Level 6 access to level 7 tub tie-in)	4 days	Tue 12/15/20	Fri 12/18/20
960	**Level 6 (13 units)**	**70 days**	**Fri 10/2/20**	**Thu 1/14/21**
961	Residents move out (follows level 8 move-in)	5 days	Fri 10/2/20	Thu 10/8/20
962	Pest Testing and Treatment	3 days	Wed 10/7/20	Fri 10/9/20
963	Plumbing/Electrical Safe-off	1 day	Mon 10/12/20	Mon 10/12/20
964	**Demo and Rough-in**	**33 days**	**Tue 10/13/20**	**Mon 11/30/20**
965	Demo bath wet wall top 2'-6" for tub tie in above	2 days	Tue 10/13/20	Wed 10/14/20
966	Tie in tubs from above	3 days	Thu 10/15/20	Mon 10/19/20
967	Remove Cabinets and Doors From Units	3 days	Thu 10/15/20	Mon 10/19/20
968	Abatement/Demo for access to Plumbing Scope	12 days	Tue 10/20/20	Wed 11/4/20
969	Repair Framing, Backing	1 day	Thu 11/5/20	Thu 11/5/20
970	Plumbing Rough-in	4 days	Fri 11/6/20	Wed 11/11/20
971	Electrical Rough-in	2 days	Tue 11/10/20	Wed 11/11/20
972	Cover Inspections	1 day	Thu 11/12/20	Thu 11/12/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

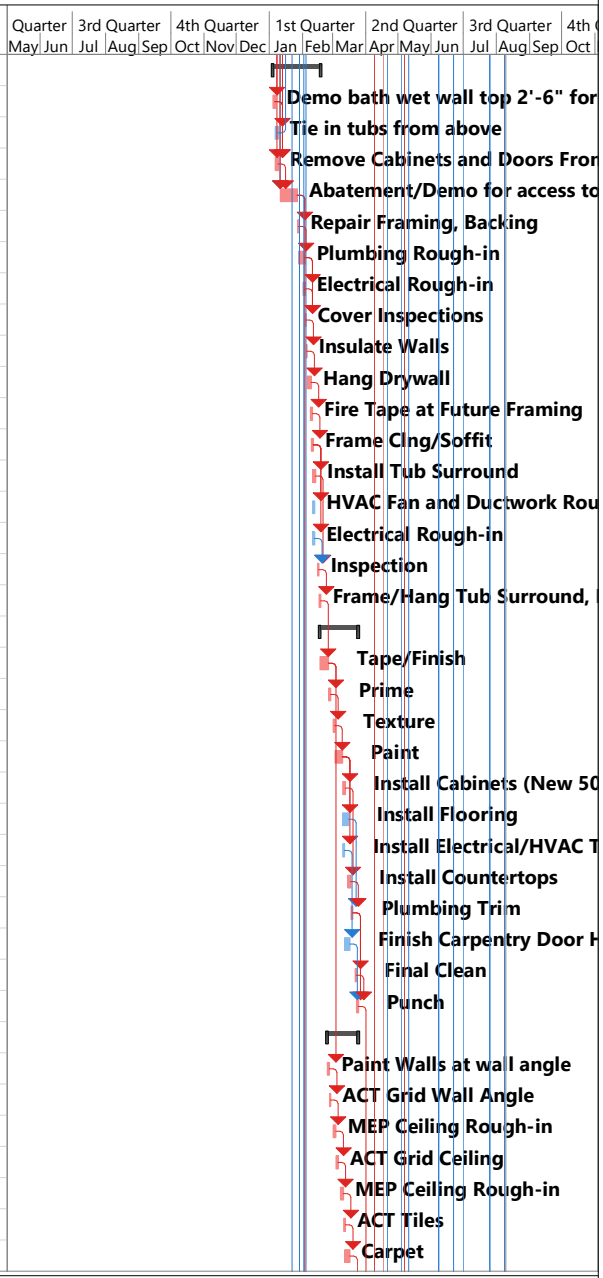
ID	Task Name	Duration	Start	Finish
973	Insulate Walls	1 day	Fri 11/13/20	Fri 11/13/20
974	Hang Drywall	2 days	Mon 11/16/20	Tue 11/17/20
975	Fire Tape at Future Framing	2 days	Tue 11/17/20	Wed 11/18/20
976	Frame Clng/Soffit	2 days	Wed 11/18/20	Thu 11/19/20
977	Install Tub Surround	3 days	Thu 11/19/20	Mon 11/23/20
978	HVAC Fan and Ductwork Rough-in	2 days	Thu 11/19/20	Fri 11/20/20
979	Electrical Rough-in	2 days	Thu 11/19/20	Fri 11/20/20
980	Inspection	1 day	Tue 11/24/20	Tue 11/24/20
981	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Wed 11/25/20	Mon 11/30/20
982	**Finishes**	**25 days**	**Mon 11/30/20**	**Wed 1/6/21**
983	Tape/Finish	6 days	Mon 11/30/20	Mon 12/7/20
984	Prime	2 days	Tue 12/8/20	Wed 12/9/20
985	Texture	2 days	Thu 12/10/20	Fri 12/11/20
986	Paint	5 days	Mon 12/14/20	Fri 12/18/20
987	Install Cabinets (New 609, 610)	3 days	Mon 12/21/20	Wed 12/23/20
988	Install Flooring	4 days	Mon 12/21/20	Mon 12/28/20
989	Install Electrical/HVAC Trim	2 days	Mon 12/21/20	Tue 12/22/20
990	Install Countertops	3 days	Mon 12/28/20	Wed 12/30/20
991	Plumbing Trim	2 days	Wed 12/30/20	Thu 12/31/20
992	Finish Carpentry Door Hdwr/Bath Accessories	3 days	Tue 12/22/20	Mon 12/28/20
993	Final Clean	1 day	Mon 1/4/21	Mon 1/4/21
994	Punch	2 days	Tue 1/5/21	Wed 1/6/21
995	**Corridor Finishes**	**21 days**	**Fri 12/4/20**	**Wed 1/6/21**
996	Paint Walls at wall angle	2 days	Fri 12/4/20	Mon 12/7/20
997	ACT Grid Wall Angle	1 day	Tue 12/8/20	Tue 12/8/20
998	MEP Ceiling Rough-in	3 days	Wed 12/9/20	Fri 12/11/20
999	ACT Grid Ceiling	2 days	Mon 12/14/20	Tue 12/15/20
1000	MEP Ceiling Rough-in	3 days	Wed 12/16/20	Fri 12/18/20
1001	ACT Tiles	2 days	Mon 12/21/20	Tue 12/22/20
1002	Carpet	3 days	Tue 12/22/20	Mon 12/28/20
1003	Paint walls	2 days	Mon 12/28/20	Tue 12/29/20
1004	Rubber Base	1 day	Wed 12/30/20	Wed 12/30/20
1005	Pre Punch	2 days	Thu 12/31/20	Mon 1/4/21
1006	Punch	2 days	Tue 1/5/21	Wed 1/6/21
1007	Residents Move-in (follows Level 5 access to level 6 tub tie-in)	4 days	Mon 1/11/21	Thu 1/14/21
1008	**Level 5 (13 units)**	**69 days**	**Mon 12/21/20**	**Tue 3/30/21**
1009	Residents move out (follow level 7 move-in)	5 days	Mon 12/21/20	Tue 12/29/20
1010	Pest Testing and Treatment	3 days	Mon 12/28/20	Wed 12/30/20
1011	Plumbing/Electrical Safe-off	1 day	Thu 12/31/20	Thu 12/31/20



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

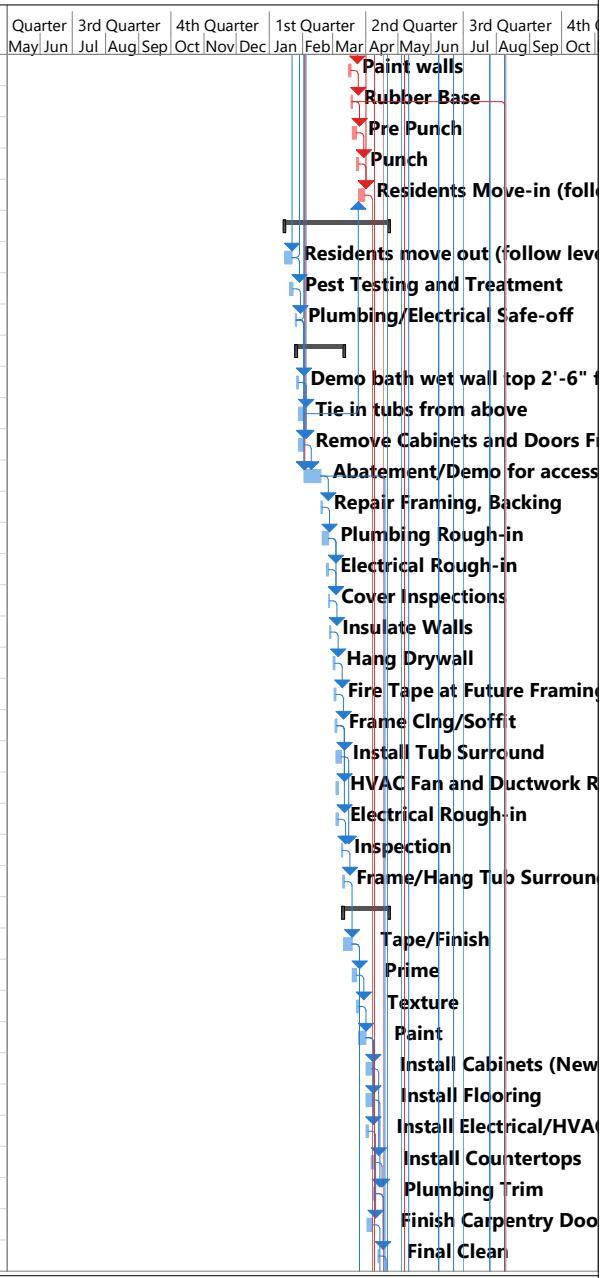
ID	Task Name	Duration	Start	Finish
1012	**Demo and Rough-in**	**33 days**	**Mon 1/4/21**	**Wed 2/17/21**
1013	Demo bath wet wall top 2'-6" for tub tie in above	2 days	Mon 1/4/21	Tue 1/5/21
1014	Tie in tubs from above	3 days	Wed 1/6/21	Fri 1/8/21
1015	Remove Cabinets and Doors From Units	3 days	Wed 1/6/21	Fri 1/8/21
1016	Abatement/Demo for access to Plumbing Scope (No 510)	12 days	Mon 1/11/21	Tue 1/26/21
1017	Repair Framing, Backing	1 day	Wed 1/27/21	Wed 1/27/21
1018	Plumbing Rough-in	4 days	Thu 1/28/21	Tue 2/2/21
1019	Electrical Rough-in	2 days	Mon 2/1/21	Tue 2/2/21
1020	Cover Inspections	1 day	Wed 2/3/21	Wed 2/3/21
1021	Insulate Walls	1 day	Thu 2/4/21	Thu 2/4/21
1022	Hang Drywall	2 days	Fri 2/5/21	Mon 2/8/21
1023	Fire Tape at Future Framing	2 days	Mon 2/8/21	Tue 2/9/21
1024	Frame Clng/Soffit	2 days	Tue 2/9/21	Wed 2/10/21
1025	Install Tub Surround	3 days	Wed 2/10/21	Fri 2/12/21
1026	HVAC Fan and Ductwork Rough-in	2 days	Wed 2/10/21	Thu 2/11/21
1027	Electrical Rough-in	2 days	Wed 2/10/21	Thu 2/11/21
1028	Inspection	1 day	Mon 2/15/21	Mon 2/15/21
1029	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Tue 2/16/21	Wed 2/17/21
1030	**Finishes**	**26 days**	**Wed 2/17/21**	**Wed 3/24/21**
1031	Tape/Finish	6 days	Wed 2/17/21	Wed 2/24/21
1032	Prime	2 days	Thu 2/25/21	Fri 2/26/21
1033	Texture	2 days	Mon 3/1/21	Tue 3/2/21
1034	Paint	5 days	Wed 3/3/21	Tue 3/9/21
1035	Install Cabinets (New 502, 503, 507, 512)	3 days	Wed 3/10/21	Fri 3/12/21
1036	Install Flooring	4 days	Wed 3/10/21	Mon 3/15/21
1037	Install Electrical/HVAC Trim	2 days	Wed 3/10/21	Thu 3/11/21
1038	Install Countertops	3 days	Mon 3/15/21	Wed 3/17/21
1039	Plumbing Trim	2 days	Thu 3/18/21	Fri 3/19/21
1040	Finish Carpentry Door Hdwr/Bath Accessories	3 days	Fri 3/12/21	Tue 3/16/21
1041	Final Clean	1 day	Mon 3/22/21	Mon 3/22/21
1042	Punch	2 days	Tue 3/23/21	Wed 3/24/21
1043	**Corridor Finishes**	**21 days**	**Wed 2/24/21**	**Wed 3/24/21**
1044	Paint Walls at wall angle	2 days	Wed 2/24/21	Thu 2/25/21
1045	ACT Grid Wall Angle	1 day	Fri 2/26/21	Fri 2/26/21
1046	MEP Ceiling Rough-in	3 days	Mon 3/1/21	Wed 3/3/21
1047	ACT Grid Ceiling	2 days	Thu 3/4/21	Fri 3/5/21
1048	MEP Ceiling Rough-in	3 days	Mon 3/8/21	Wed 3/10/21
1049	ACT Tiles	2 days	Thu 3/11/21	Fri 3/12/21
1050	Carpet	3 days	Fri 3/12/21	Tue 3/16/21



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

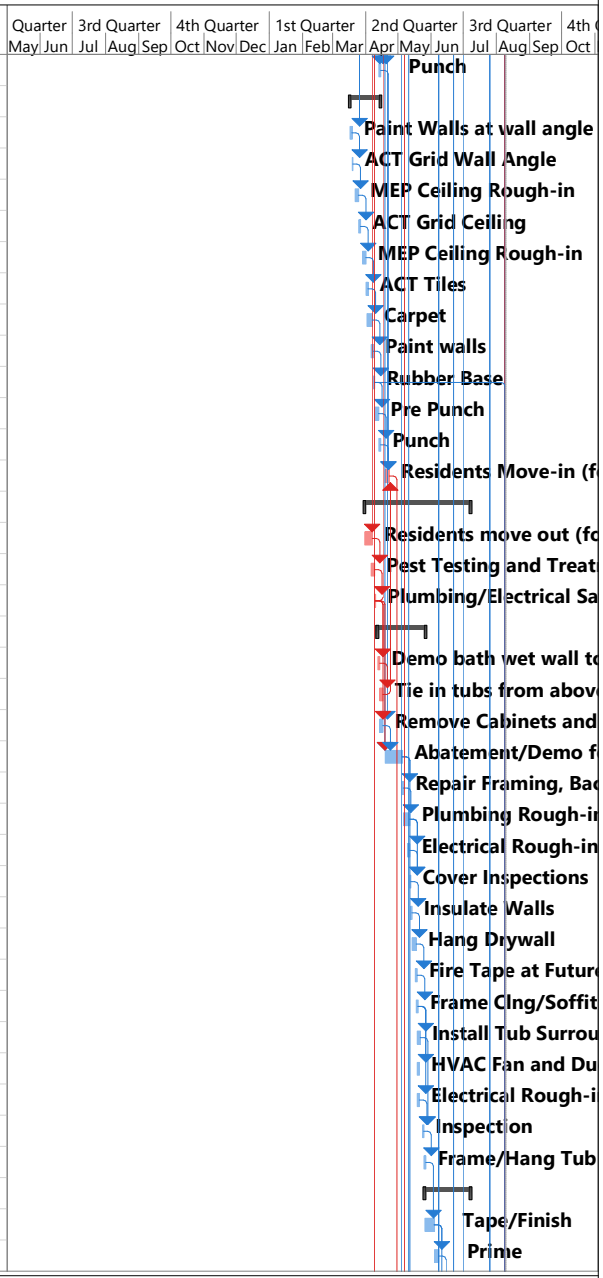
ID	Task Name	Duration	Start	Finish
1051	Paint walls	2 days	Tue 3/16/21	Wed 3/17/21
1052	Rubber Base	1 day	Thu 3/18/21	Thu 3/18/21
1053	Pre Punch	2 days	Fri 3/19/21	Mon 3/22/21
1054	Punch	2 days	Tue 3/23/21	Wed 3/24/21
1055	Residents Move-in (follows Level 4 access to level 5 tub tie-in)	4 days	Thu 3/25/21	Tue 3/30/21
1056	**Level 4 (13 units)**	**70 days**	**Fri 1/15/21**	**Thu 4/22/21**
1057	Residents move out (follow level 6 move-in)	5 days	Fri 1/15/21	Thu 1/21/21
1058	Pest Testing and Treatment	3 days	Wed 1/20/21	Fri 1/22/21
1059	Plumbing/Electrical Safe-off	1 day	Mon 1/25/21	Mon 1/25/21
1060	**Demo and Rough-in**	**33 days**	**Tue 1/26/21**	**Thu 3/11/21**
1061	Demo bath wet wall top 2'-6" for tub tie in above	2 days	Tue 1/26/21	Wed 1/27/21
1062	Tie in tubs from above	3 days	Thu 1/28/21	Mon 2/1/21
1063	Remove Cabinets and Doors From Units	3 days	Thu 1/28/21	Mon 2/1/21
1064	Abatement/Demo for access to Plumbing Scope (No 401, 402, 413)	12 days	Tue 2/2/21	Wed 2/17/21
1065	Repair Framing, Backing	1 day	Thu 2/18/21	Thu 2/18/21
1066	Plumbing Rough-in	4 days	Fri 2/19/21	Wed 2/24/21
1067	Electrical Rough-in	2 days	Tue 2/23/21	Wed 2/24/21
1068	Cover Inspections	1 day	Thu 2/25/21	Thu 2/25/21
1069	Insulate Walls	1 day	Fri 2/26/21	Fri 2/26/21
1070	Hang Drywall	2 days	Mon 3/1/21	Tue 3/2/21
1071	Fire Tape at Future Framing	2 days	Tue 3/2/21	Wed 3/3/21
1072	Frame Clng/Soffit	2 days	Wed 3/3/21	Thu 3/4/21
1073	Install Tub Surround	3 days	Thu 3/4/21	Mon 3/8/21
1074	HVAC Fan and Ductwork Rough-in	2 days	Thu 3/4/21	Fri 3/5/21
1075	Electrical Rough-in	2 days	Thu 3/4/21	Fri 3/5/21
1076	Inspection	1 day	Tue 3/9/21	Tue 3/9/21
1077	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Wed 3/10/21	Thu 3/11/21
1078	**Finishes**	**31 days**	**Thu 3/11/21**	**Thu 4/22/21**
1079	Tape/Finish	6 days	Thu 3/11/21	Thu 3/18/21
1080	Prime	2 days	Fri 3/19/21	Mon 3/22/21
1081	Texture	2 days	Tue 3/23/21	Wed 3/24/21
1082	Paint	5 days	Thu 3/25/21	Wed 3/31/21
1083	Install Cabinets (New 409, 411)	3 days	Thu 4/1/21	Mon 4/5/21
1084	Install Flooring	4 days	Thu 4/1/21	Tue 4/6/21
1085	Install Electrical/HVAC Trim	2 days	Thu 4/1/21	Fri 4/2/21
1086	Install Countertops	3 days	Tue 4/6/21	Thu 4/8/21
1087	Plumbing Trim	2 days	Thu 4/8/21	Fri 4/9/21
1088	Finish Carpentry Door Hdwr/Bath Accessories	3 days	Fri 4/2/21	Tue 4/6/21
1089	Final Clean	1 day	Mon 4/12/21	Mon 4/12/21



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

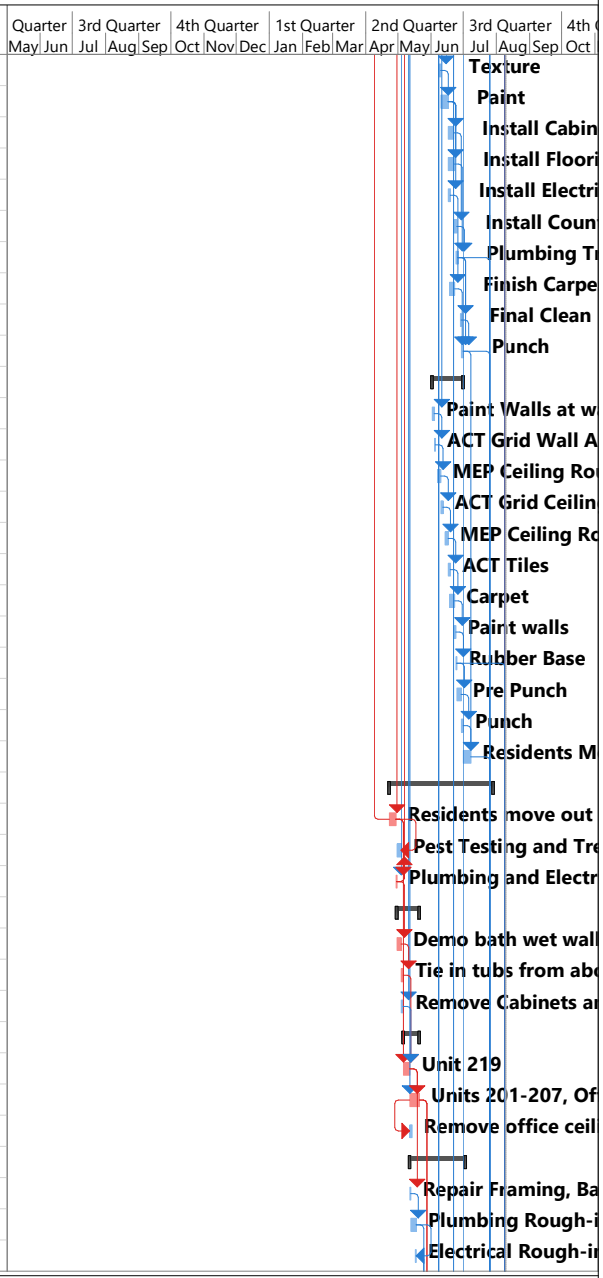
ID	Task Name	Duration	Start	Finish
1090	Punch	2 days	Tue 4/13/21	Wed 4/14/21
1091	**Corridor Finishes**	**21 days**	**Wed 3/17/21**	**Wed 4/14/21**
1092	Paint Walls at wall angle	2 days	Wed 3/17/21	Thu 3/18/21
1093	ACT Grid Wall Angle	1 day	Fri 3/19/21	Fri 3/19/21
1094	MEP Ceiling Rough-in	3 days	Mon 3/22/21	Wed 3/24/21
1095	ACT Grid Ceiling	2 days	Thu 3/25/21	Fri 3/26/21
1096	MEP Ceiling Rough-in	3 days	Mon 3/29/21	Wed 3/31/21
1097	ACT Tiles	2 days	Thu 4/1/21	Fri 4/2/21
1098	Carpet	3 days	Fri 4/2/21	Tue 4/6/21
1099	Paint walls	2 days	Tue 4/6/21	Wed 4/7/21
1100	Rubber Base	1 day	Thu 4/8/21	Thu 4/8/21
1101	Pre Punch	2 days	Fri 4/9/21	Mon 4/12/21
1102	Punch	2 days	Tue 4/13/21	Wed 4/14/21
1103	Residents Move-in (follow level 3 access to level 4 tub tie-in)	4 days	Mon 4/19/21	Thu 4/22/21
1104	**Level 3 (13 units)**	**69 days**	**Wed 3/31/21**	**Wed 7/7/21**
1105	Residents move out (follow level 5 move-in)	5 days	Wed 3/31/21	Tue 4/6/21
1106	Pest Testing and Treatment	3 days	Tue 4/6/21	Thu 4/8/21
1107	Plumbing/Electrical Safe-off	1 day	Fri 4/9/21	Fri 4/9/21
1108	**Demo and Rough-in**	**33 days**	**Mon 4/12/21**	**Wed 5/26/21**
1109	Demo bath wet wall top 2'-6" for tub tie in above	2 days	Mon 4/12/21	Tue 4/13/21
1110	Tie in tubs from above	3 days	Wed 4/14/21	Fri 4/16/21
1111	Remove Cabinets and Doors From Units	3 days	Wed 4/14/21	Fri 4/16/21
1112	Abatement/Demo for access to Plumbing Scope (No 307, 312, 313)	12 days	Mon 4/19/21	Tue 5/4/21
1113	Repair Framing, Backing	1 day	Wed 5/5/21	Wed 5/5/21
1114	Plumbing Rough-in	4 days	Thu 5/6/21	Tue 5/11/21
1115	Electrical Rough-in	2 days	Mon 5/10/21	Tue 5/11/21
1116	Cover Inspections	1 day	Wed 5/12/21	Wed 5/12/21
1117	Insulate Walls	1 day	Thu 5/13/21	Thu 5/13/21
1118	Hang Drywall	2 days	Fri 5/14/21	Mon 5/17/21
1119	Fire Tape at Future Framing	2 days	Mon 5/17/21	Tue 5/18/21
1120	Frame Clng/Soffit	2 days	Tue 5/18/21	Wed 5/19/21
1121	Install Tub Surround	3 days	Wed 5/19/21	Fri 5/21/21
1122	HVAC Fan and Ductwork Rough-in	2 days	Wed 5/19/21	Thu 5/20/21
1123	Electrical Rough-in	2 days	Wed 5/19/21	Thu 5/20/21
1124	Inspection	1 day	Mon 5/24/21	Mon 5/24/21
1125	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Tue 5/25/21	Wed 5/26/21
1126	**Finishes**	**29 days**	**Wed 5/26/21**	**Wed 7/7/21**
1127	Tape/Finish	6 days	Wed 5/26/21	Thu 6/3/21
1128	Prime	2 days	Fri 6/4/21	Mon 6/7/21



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

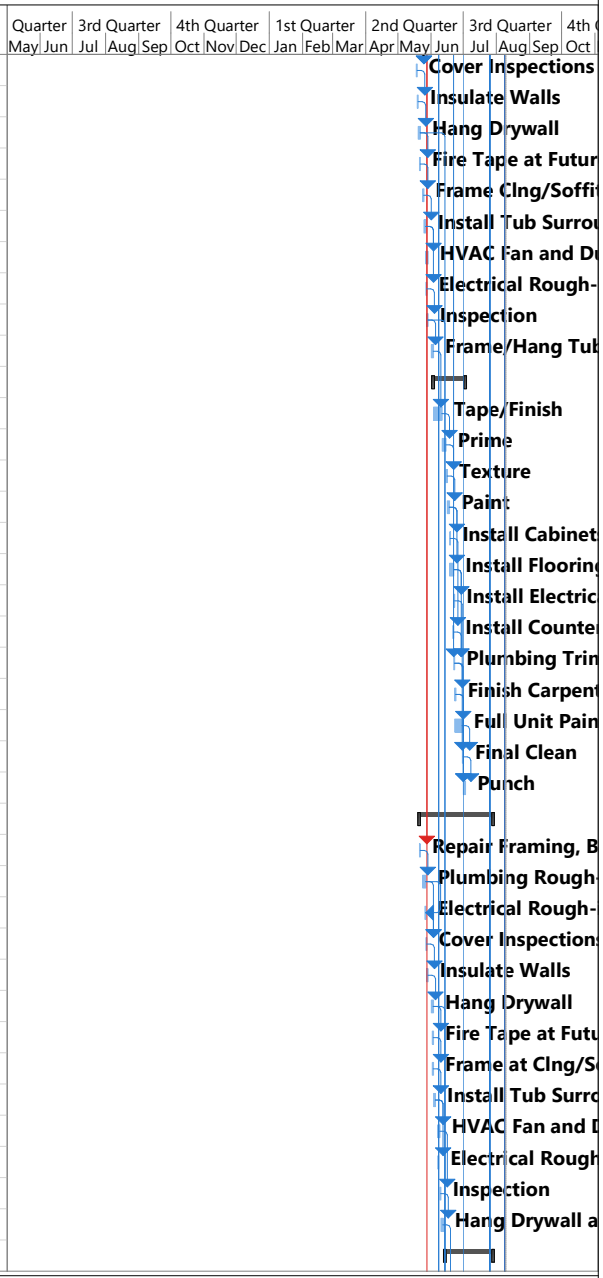
ID	Task Name	Duration	Start	Finish
1129	Texture	2 days	Tue 6/8/21	Wed 6/9/21
1130	Paint	5 days	Thu 6/10/21	Wed 6/16/21
1131	Install Cabinets	3 days	Thu 6/17/21	Mon 6/21/21
1132	Install Flooring	4 days	Thu 6/17/21	Tue 6/22/21
1133	Install Electrical/HVAC Trim	2 days	Thu 6/17/21	Fri 6/18/21
1134	Install Countertops	3 days	Tue 6/22/21	Thu 6/24/21
1135	Plumbing Trim	2 days	Thu 6/24/21	Fri 6/25/21
1136	Finish Carpentry Door Hdwr/Bath Accessories	3 days	Fri 6/18/21	Tue 6/22/21
1137	Final Clean	1 day	Mon 6/28/21	Mon 6/28/21
1138	Punch	2 days	Tue 6/29/21	Wed 6/30/21
1139	**Corridor Finishes**	**21 days**	**Wed 6/2/21**	**Wed 6/30/21**
1140	Paint Walls at wall angle	2 days	Wed 6/2/21	Thu 6/3/21
1141	ACT Grid Wall Angle	1 day	Fri 6/4/21	Fri 6/4/21
1142	MEP Ceiling Rough-in	3 days	Mon 6/7/21	Wed 6/9/21
1143	ACT Grid Ceiling	2 days	Thu 6/10/21	Fri 6/11/21
1144	MEP Ceiling Rough-in	3 days	Mon 6/14/21	Wed 6/16/21
1145	ACT Tiles	2 days	Thu 6/17/21	Fri 6/18/21
1146	Carpet	3 days	Fri 6/18/21	Tue 6/22/21
1147	Paint walls	2 days	Tue 6/22/21	Wed 6/23/21
1148	Rubber Base	1 day	Thu 6/24/21	Thu 6/24/21
1149	Pre Punch	2 days	Fri 6/25/21	Mon 6/28/21
1150	Punch	2 days	Tue 6/29/21	Wed 6/30/21
1151	Residents Move-in (follows Level 2 access to level 3 tub tie-in)	4 days	Thu 7/1/21	Wed 7/7/21
1152	**2nd Floor - 9 Units Plus Office**	**67 days**	**Fri 4/23/21**	**Wed 7/28/21**
1153	Residents move out (follow level 4 move-in)	4 days	Fri 4/23/21	Wed 4/28/21
1154	Pest Testing and Treatment	2 days	Fri 4/30/21	Mon 5/3/21
1155	Plumbing and Electrical Safe-off	1 day	Thu 4/29/21	Thu 4/29/21
1156	**Abatement / Demo**	**15 days**	**Fri 4/30/21**	**Thu 5/20/21**
1157	Demo bath wet wall top 2'-6" for tub tie in above	2 days	Fri 4/30/21	Mon 5/3/21
1158	Tie in tubs from above	2 days	Tue 5/4/21	Wed 5/5/21
1159	Remove Cabinets and Doors From Units	2 days	Tue 5/4/21	Wed 5/5/21
1160	**Abate full unit ceilings AND walls for base scope**	**11 days**	**Thu 5/6/21**	**Thu 5/20/21**
1161	Unit 219	4 days	Thu 5/6/21	Tue 5/11/21
1162	Units 201-207, Office Area	7 days	Wed 5/12/21	Thu 5/20/21
1163	Remove office ceiling / walls / flooring	2 days	Wed 5/12/21	Thu 5/13/21
1164	**Units East**	**37 days**	**Wed 5/12/21**	**Fri 7/2/21**
1165	Repair Framing, Backing	1 day	Wed 5/12/21	Wed 5/12/21
1166	Plumbing Rough-in	3 days	Thu 5/13/21	Mon 5/17/21
1167	Electrical Rough-in	1 day	Mon 5/17/21	Mon 5/17/21



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

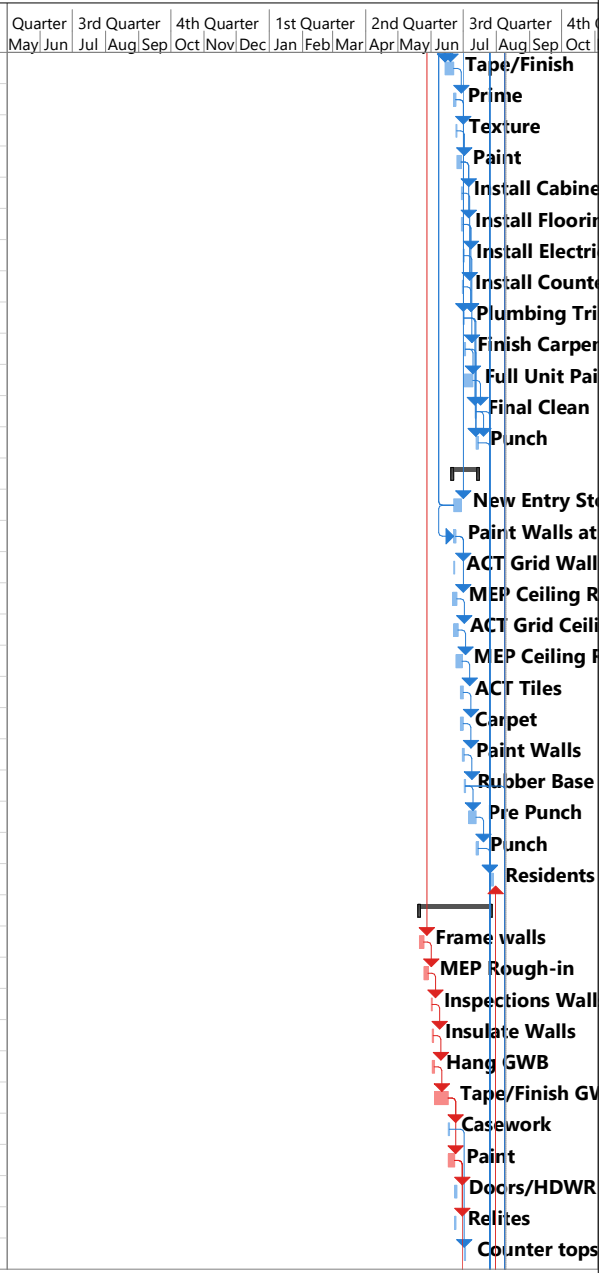
ID	Task Name	Duration	Start	Finish
1168	Cover Inspections	1 day	Tue 5/18/21	Tue 5/18/21
1169	Insulate Walls	1 day	Wed 5/19/21	Wed 5/19/21
1170	Hang Drywall	2 days	Thu 5/20/21	Fri 5/21/21
1171	Fire Tape at Future Framing	1 day	Fri 5/21/21	Fri 5/21/21
1172	Frame Clng/Soffit	1 day	Mon 5/24/21	Mon 5/24/21
1173	Install Tub Surround	2 days	Tue 5/25/21	Wed 5/26/21
1174	HVAC Fan and Ductwork Rough-in	2 days	Thu 5/27/21	Fri 5/28/21
1175	Electrical Rough-in	1 day	Thu 5/27/21	Thu 5/27/21
1176	Inspection	1 day	Fri 5/28/21	Fri 5/28/21
1177	Frame/Hang Tub Surround, Hang Clng/Soffit	2 days	Tue 6/1/21	Wed 6/2/21
1178	**Finishes**	**22 days**	**Thu 6/3/21**	**Fri 7/2/21**
1179	Tape/Finish	6 days	Thu 6/3/21	Thu 6/10/21
1180	Prime	2 days	Fri 6/11/21	Mon 6/14/21
1181	Texture	1 day	Tue 6/15/21	Tue 6/15/21
1182	Paint	2 days	Wed 6/16/21	Thu 6/17/21
1183	Install Cabinets	1 day	Fri 6/18/21	Fri 6/18/21
1184	Install Flooring (bathroom)	2 days	Fri 6/18/21	Mon 6/21/21
1185	Install Electrical/HVAC Trim	1 day	Tue 6/22/21	Tue 6/22/21
1186	Install Countertops	1 day	Mon 6/21/21	Mon 6/21/21
1187	Plumbing Trim	1 day	Tue 6/22/21	Tue 6/22/21
1188	Finish Carpentry	1 day	Wed 6/23/21	Wed 6/23/21
1189	Full Unit Paint	5 days	Wed 6/23/21	Tue 6/29/21
1190	Final Clean	1 day	Wed 6/30/21	Wed 6/30/21
1191	Punch	2 days	Thu 7/1/21	Fri 7/2/21
1192	**Units West**	**47 days**	**Fri 5/21/21**	**Wed 7/28/21**
1193	Repair Framing, Backing	1 day	Fri 5/21/21	Fri 5/21/21
1194	Plumbing Rough-in	3 days	Mon 5/24/21	Wed 5/26/21
1195	Electrical Rough-in	1 day	Wed 5/26/21	Wed 5/26/21
1196	Cover Inspections	1 day	Thu 5/27/21	Thu 5/27/21
1197	Insulate Walls	1 day	Fri 5/28/21	Fri 5/28/21
1198	Hang Drywall	2 days	Tue 6/1/21	Wed 6/2/21
1199	Fire Tape at Future Framing	1 day	Wed 6/2/21	Wed 6/2/21
1200	Frame at Clng/Soffit	1 day	Wed 6/2/21	Wed 6/2/21
1201	Install Tub Surround	2 days	Thu 6/3/21	Fri 6/4/21
1202	HVAC Fan and Ductwork Rough-in	2 days	Mon 6/7/21	Tue 6/8/21
1203	Electrical Rough-in	1 day	Mon 6/7/21	Mon 6/7/21
1204	Inspection	1 day	Wed 6/9/21	Wed 6/9/21
1205	Hang Drywall at Tub Surround/Clng/Soffit	2 days	Thu 6/10/21	Fri 6/11/21
1206	**Finishes**	**32 days**	**Mon 6/14/21**	**Wed 7/28/21**



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

ID	Task Name	Duration	Start	Finish
1207	Tape/Finish	6 days	Mon 6/14/21	Mon 6/21/21
1208	Prime	2 days	Tue 6/22/21	Wed 6/23/21
1209	Texture	1 day	Thu 6/24/21	Thu 6/24/21
1210	Paint	2 days	Fri 6/25/21	Mon 6/28/21
1211	Install Cabinets (New 207)	1 day	Tue 6/29/21	Tue 6/29/21
1212	Install Flooring (bathroom)	2 days	Tue 6/29/21	Wed 6/30/21
1213	Install Electrical/HVAC Trim	1 day	Thu 7/1/21	Thu 7/1/21
1214	Install Countertops	1 day	Wed 6/30/21	Wed 6/30/21
1215	Plumbing Trim	1 day	Thu 7/1/21	Thu 7/1/21
1216	Finish Carpentry	1 day	Fri 7/2/21	Fri 7/2/21
1217	Full Unit Paint	5 days	Fri 7/2/21	Fri 7/9/21
1218	Final Clean	1 day	Mon 7/12/21	Mon 7/12/21
1219	Punch	2 days	Tue 7/13/21	Wed 7/14/21
1220	**Corridor Finishes**	**17 days**	**Mon 6/21/21**	**Wed 7/14/21**
1221	New Entry Storefront	5 days	Tue 6/22/21	Mon 6/28/21
1222	Paint Walls at wall angle	2 days	Tue 6/22/21	Wed 6/23/21
1223	ACT Grid Wall Angle	1 day	Tue 6/22/21	Tue 6/22/21
1224	MEP Ceiling Rough-in	4 days	Mon 6/21/21	Thu 6/24/21
1225	ACT Grid Ceiling	4 days	Tue 6/22/21	Fri 6/25/21
1226	MEP Ceiling Rough-in	4 days	Thu 6/24/21	Tue 6/29/21
1227	ACT Tiles	3 days	Mon 6/28/21	Wed 6/30/21
1228	Carpet	3 days	Mon 6/28/21	Wed 6/30/21
1229	Paint Walls	2 days	Wed 6/30/21	Thu 7/1/21
1230	Rubber Base	1 day	Fri 7/2/21	Fri 7/2/21
1231	Pre Punch	5 days	Tue 7/6/21	Mon 7/12/21
1232	Punch	2 days	Tue 7/13/21	Wed 7/14/21
1233	Residents Move back- 5 per day	3 days	Mon 7/26/21	Wed 7/28/21
1234	**Office Area**	**45 days**	**Fri 5/21/21**	**Mon 7/26/21**
1235	Frame walls	2 days	Fri 5/21/21	Mon 5/24/21
1236	MEP Rough-in	4 days	Tue 5/25/21	Fri 5/28/21
1237	Inspections Walls	1 day	Tue 6/1/21	Tue 6/1/21
1238	Insulate Walls	1 day	Wed 6/2/21	Wed 6/2/21
1239	Hang GWB	2 days	Wed 6/2/21	Thu 6/3/21
1240	Tape/Finish GWB	9 days	Fri 6/4/21	Wed 6/16/21
1241	Casework	1 day	Thu 6/17/21	Thu 6/17/21
1242	Paint	4 days	Thu 6/17/21	Tue 6/22/21
1243	Doors/HDWR	2 days	Wed 6/23/21	Thu 6/24/21
1244	Relites	1 day	Wed 6/23/21	Wed 6/23/21
1245	Counter tops	1 day	Fri 7/2/21	Fri 7/2/21



Walsh Construciton
Wed 4/1/20

Hillside Schedule
Horizontal Sequence
(26) Units Vacant
ALL Units Ceiling ACM Abatement

ID	Task Name	Duration	Start	Finish
1246	Ceiling grid	3 days	Wed 6/23/21	Fri 6/25/21
1247	Ceiling Rough-in	4 days	Mon 6/28/21	Thu 7/1/21
1248	Inspections Ceilings	1 day	Fri 7/2/21	Fri 7/2/21
1249	Drop Ceiling tile	2 days	Tue 7/6/21	Wed 7/7/21
1250	Flooring	3 days	Thu 7/8/21	Mon 7/12/21
1251	Restroom Accessories	1 day	Tue 7/13/21	Tue 7/13/21
1252	MEP Trim	3 days	Tue 7/13/21	Thu 7/15/21
1253	Final Clean	1 day	Fri 7/16/21	Fri 7/16/21
1254	Punch	5 days	Mon 7/19/21	Fri 7/23/21
1255	Property Mgmt move back	1 day	Mon 7/26/21	Mon 7/26/21
1256	Inspections / TCO	10 days	Mon 7/26/21	Fri 8/6/21
1257	Building Completion	1 day	Mon 8/9/21	Mon 8/9/21

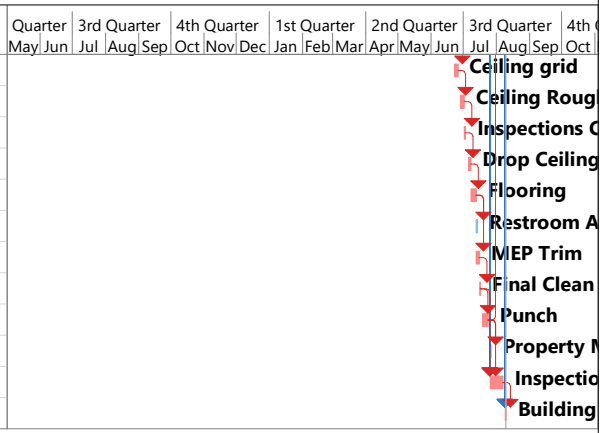


Exhibit A.8

DIRECT COSTS/GENERAL CONDITIONS WORK COSTS MATRIX

		Construction costs/Paid by Owner				
	Description	**Direct Cost of the Work**	**General Conditions Work Costs**	**General Conditions Work Costs**	**Contractor's O/H Part of CM/GC's Fee**	**Misc. Costs Paid by Owner**
Costs Related to CM Staffing & Job Office						
1	Project Superintendent		X	$ 293,139		
2	Area Superintendents		X			
3	Project Executive (for project specific time only)		X*	$ 39,668		
4	Senior Project Manager (for project specific time only)		X	$ 171,798		
5	Project Manager		X	$ 62,550		
6	Project Engineers		X	$ 216,000		
7	Field Engineers- Tenant Relocation		X**	$ 38,086		
8	Project Admin		X*, **	$ 88,050		
9	Scheduler (for project specific time only)		X			
10	MEP Coordinator (for project specific time only)		X			
11	LEED Coordinator (for project specific time only)		X			
11b	Quality Control Inspections	X				
12	Safety Coordinator Inspections (for project specific time only)	X				
13	Detailer	X				
14	Accounting/Data Processing				X	
15	Payroll Accountant				X	
16	Surveying	X				
17	Benefits - included in hourly rates		X			
18	Vacation Time - included in hourly rates		X			
19	Travel, Hotel, Meals, etc. (in accordance with Agreement for product verification only)		X			
20	Sick Leave - included in hourly rates		X			
21	Bonuses				X	
22	Jobsite Office material costs and expendables		X			
23	Warranty				X	
24	Corrective/Non-conforming repair				X	
25	Corrective work not due to contractor default				X	
26	PM auto rental		X			
27	PM auto fuel for on-site job-related errands only - not travel from home	X				
28	Project Superintendent truck rental		X			
29	Project Superintendent truck fuel for on-site job-related errands only - not travel from home (see above)	X				
30	Office Trailer Rental		X	$ 26,175		
31	Office Furniture/Equipment		X*	$ 14,650		
32	Blueprints for sub bidding		X*			
33	Blueprints for day-to-day job operations / Digital Record Set	X				
34	Postage/FedEx		X	$ 16,750		
35	Project Photos		X			
36	Personal Comupters/software				X	
36b	Work Computers/ IT Support / Software Rental		X	$ 38,068		
37	General Contractor Bond	X				
38	Subcontractor Bonds - none included	X*				

Exhibit A.8

		Construction costs/Paid by Owner				
	Description	**Direct Cost of the Work**	**General Conditions Work Costs**		**Contractor's O/H Part of CM/GC's Fee**	**Misc. Costs Paid by Owner**
39	Insurance GL, Worker's Comp, Auto (in accordance with contract only)	X				
40	Insurance All Risk					X
41	Soils report					X
42	Testing and Inspections					X
43	Facility training	X				
44	Building Permits/Fees					X
45	Development Permits/fees					X
46	Estimating				X	
47	Value engineering				X	
48	Corporate accounting				X	
49	Corporate safety officer				X	
50	Main office administration				X	
51	Corporate IT director				X	
52	Legal				X	
53	Main office payroll costs				X	
54	Main office fringe/bonus costs				X	
55	Construction Wages for trade labor	X*				
56	Labor Burden for trade labor	X*				
57	Subcontracts	X				
58	Material & Equipment related to craft labor & site logistics	X				
59	Rental-Contractor Owned equip (less than $2000 will be purchased)	X*				
60	Small Tools (less than $2000 will be purchased)	X*				
61	Flatbed truck rental/operation	X				
62	Flatbed truck fuel	X				
63	Water truck	X				
64	Air Compressor	X				
65	Water pumping equipment	X				
66	Other dewatering equipment	X				
67	Equipment rental -third party	X				
68	Storage Trailer rental	X				
69	Temporary Toilets		X	$ 26,730		
70	Project Signage		X	$ 1,200		
71	Temporary Fencing	X				
72	Barricades	X				
73	Temporary Enclosures	X				
74	Temporary Stairs	X				
75	Opening Protection	X				
76	Safety railing and nets	X				
77	Drinking water (NOT coffee) and supplies (cups)		X	$ 6,700		
78	Safety equipment for CMGC personnel. Generic only - not logo materials. Subs provide own	X	X			
79	First Aid supplies for CMGC personnel. Subs provide own in COW.	X	X			
80	Security					X

Exhibit A.8

		Construction costs/Paid by Owner				
	Description	**Direct Cost of the Work**	**General Conditions Work Costs**		**Contractor's O/H Part of CM/GC's Fee**	**Misc. Costs Paid by Owner**
81	Weather protection		X			
81.b	Weather protection for Subs	X				
82	Mobilization/Demobilization		X	$ 3,000		
82.b	Mobilization/Demobilization for Subs	X				
83	Craft Parking		X			
84	Craft Shuttles / Trimet		X	$ 2,010		
85	Telephone and Data line Installation		X	$ 16,658		
86	Telephone Bills (On-site hard line phone service - if cell phones max $50/mo reimbursement		X	$ 4,153		
87	Temp utilities hookup	X				
88	Temp utility bills					X
89	Periodic Cleanup	X				
90	Final cleanup	X				
91	Dump permits/fees	X				
92	Trash removal/Hauling	X				
93	Flagging/Traffic control	X				
94	Dust Control	X				
95	Trash chute	X				
96	Trade permits	X				
97	Manlift Materials and Rental	X				
98	Manlift Erect/Dismantle	X				
99	Manlift operator	X				
100	Man- Matieral Hoist - Materials and Rental	X				
101	Man- Matieral Hoist - Erect/Dismantle	X				
102	Man- Matieral Hoist -operator	X				
103	Crane rental	X				
104	Crane operator & bellman	X				
105	Crane Erect/Dismantle/Jump	X				
106	Crane Service agreement costs	X				
107	Temp elevator operator - n/a	X				
108	Temp elevator agreement- n/a	X				
109	Forklift rental	X				
110	Forklift operator	X				
111	Equipment Fuel	X				
112	Closeout		X	$ 5,000		
113	New Hire Training		X	$ 2,400		
114	Oregon Gross Business Tax	X				
		*Subject to Negotiation				
	** Field Engineer = install, adjust, and/or trouble-shoot equipment					
	*** - Project Admin = on-site office manager, payroll, clerical services			$ 1,072,783		

SECTION 02 82 13 ASBESTOS ABATEMENT

PART 1 GENERAL

1.1 SCOPE

A. This section covers the removal and repair of materials that contain, or are presumed to contain, greater than one percent asbestos.

B. The abatement contractor shall provide all labor, materials, equipment, services, permits, and insurance required to complete asbestos abatement procedures as indicated in these Specifications. The abatement contractor shall perform all selective demolition as needed to access and abate asbestos-containing materials.

C. The General Contractor and its subcontractors shall familiarize themselves with the material types, locations and quantities of asbestos-containing building materials at the site.

D. Refer to the Asbestos-Containing Building Materials Survey Report, PBS Engineering and Environmental, June 2019 for information on asbestos-containing materials within the building. The table below summarizes the asbestos-containing building materials identified at the site.

E. Table 1. Asbestos-Containing Materials

Asbestos-Containing Building Materials
Textured Ceiling Material
Vinyl Floor Tile & Associated Mastic
Interior Wall to Ceiling Caulk/Sealant
Felt Duct Tape
Black Floor Mastic
Black Coating on Stainless Steel Sinks
Interior Kitchen Sealants
Materials Containing Less Than One Percent Asbestos
Joint Compound
Ceramic Tile Grout

F. The asbestos-containing building materials listed above and in the associated survey do not necessarily represent materials requiring abatement to facilitate the planned facility renovations. Rather, they are the materials that were identified within, or immediately adjacent to, the work items and work areas. While many of these materials may require abatement, some may be able to safely remain during the project. ACM should be managed in place unless abatement is warranted.

G. Although the work under the renovation project may not impact all of these asbestos-containing building materials, it is important to communicate the hazards to all individuals involved in the project in order to meet Oregon OSHA Hazard Communication requirements and avoid accidental damage to ACM during construction.

1.2 DEFINITIONS

A. Abatement: Procedures to control fiber release from asbestos-containing building materials, which include encapsulation, enclosure, removal, repair, and related activities.

B. Aggressive Sampling: Air sampling method that assures that asbestos fibers remain airborne during sampling. All surfaces inside the work area will be agitated by the liberal use of compressed air, leaf blowers, or similar. Fans will then be run throughout the sampling period to keep all suspended fibers airborne.

C. AHERA: Asbestos Hazard Emergency Response Act, 40 CFR Part 763.

D. Air Lock: A system for permitting ingress or egress without permitting air movement between a contaminated area and an uncontaminated area, typically consisting of two curtained doorways at least three feet apart.

E. Air Monitoring: The process of measuring the asbestos fiber content of a specific volume of air in a stated period of time.

F. Amended Water: Water containing a surfactant additive.

G. Asbestos-containing Material (ACM): Any material containing more than one percent asbestos as defined under NESHAPS CFR 40, Part 61, OAR Chapter 340, Division 248, OR-OSHA 437, 1926.1101, and OSHA 29 CFR Part 1926.1101.

H. Authorized Visitor: The owner or designated representative, or a representative of any regulatory or other agency having jurisdiction over the project, and having required training, medical, fit test, etc.

I. Certified Industrial Hygienist (CIH): An industrial hygienist certified in comprehensive practice by the American Board of Industrial Hygiene.

J. Construction, Manager/General Contractor (CMGC): A construction delivery method in which the construction manager acts as the general contractor with schedule and cost risk. The CMGC provides design phase assistance in evaluating costs, schedule, and implications of systems and materials during design.

K. Class I Asbestos Work: Activities involving the removal of TSI and surfacing ACM and PACM.

L. Class II Asbestos Work: Activities involving the removal of ACM, which is not thermal system insulation or surfacing material. This includes, but is not limited to, the removal of asbestos-containing wallboard, floor tile and sheeting, roofing and siding shingles, and mastics.

M. Clean Room: An uncontaminated area or room that is part of the worker decontamination enclosure system, with provisions for storing workers' street clothes and clean protective equipment.

N. Critical Barrier: Solid barrier constructed from minimum of 2- by 4-inch studs, 16-inch o.c.; 0.5-inch plywood or drywall sealed airtight and covered on both sides (where applicable) with two layers of 6-mil plastic.

O. Curtained Doorway: A device to allow ingress or egress from one room to another while permitting minimal air movement between the rooms, typically constructed by placing three overlapping sheets of plastic over an existing or temporarily-framed doorway, securing each along the top of the doorway in a pleated fashion and securing one vertical side of each sheet on alternating sides of consecutive sheets. Two curtained doorways spaced a minimum of three feet apart to form an air lock.

P. Disposal: Procedures necessary to transport and deposit the asbestos-contaminated material in an approved waste disposal site in compliance with the Environmental Protection Agency (EPA) and other applicable regulations.

Q. Enclosure: Procedures necessary to completely seal all asbestos-containing material behind airtight, impermeable, permanent barriers, including PVC jackets.

R. Encapsulant (Sealant): A liquid material that can be applied to asbestos-containing material and that controls the possible release of asbestos fibers from the material either by creating a membrane over the surface (bridging encapsulant), or by penetrating the material and binding its components together (penetrating encapsulant).

S. Environmental Consultant: Environmental consultant specializing in asbestos abatement—PBS Engineering and Environmental Inc., 4412 SW Corbett Avenue, Portland, Oregon, 97239, 503.248.1939.

T. Equipment Room: A contaminated area or room, which is part of the worker decontamination enclosure system, with provisions for storage of contaminated clothing and equipment.

U. Fitting: With regard to pipe insulation, a fitting is any elbow, offset, reducer, tee, etc.

V. Fixed Object: Fixtures that are attached to the building or too heavy or bulky to remove from the work area.

W. Glovebag: A manufactured device consisting of a transparent plastic bag with inward projecting sleeves, an internal tool pouch, provisions for fastening and sealing at the top and sides, and a receptacle in the bottom to hold asbestos waste. The glovebag is installed to surround the material to be removed and contain all fibers released during the process. Glovebags are used to remove insulation from small sections of pipe and fittings.

X. HEPA Filter: A high efficiency particulate air (absolute) filter capable of trapping and retaining 99.97 percent of asbestos fibers greater than 0.3 microns in length.

Y. HEPA Vacuum Equipment: High efficiency particulate air (absolute) filtered vacuuming equipment with a filter system capable of collecting and retaining asbestos fibers. Filters of 99.97 percent efficiency for retaining fibers of 0.3 microns in length or larger shall be installed for filtering discharge air.

Z. Independent Testing Laboratory: A laboratory financially independent from and hired by the owner, architect, or contractor that is either AIHA-accredited for asbestos with demonstrated proficiency via the AIHA PAT program, or has analysts proficient in the AIHA AAR program for air sample analysis.

AA. Industrial Hygienist: An employee of the Independent Testing Laboratory who is experienced and trained in asbestos sampling and analysis as specified.

BB. Insulating Cement: Cementitious material applied to pipe reducers, manifolds, etc.

CC. Isolated Work Area: A totally contained area of the facility where abatement activities are performed.

DD. Movable Object: Furnishings not attached to the building structure that can be removed from the work area.

EE. Negative-air Glovebag: A manufactured device consisting of a transparent plastic bag with inward projecting sleeves, an internal tool pouch, provisions for fastening and sealing it at the top and sides, and a receptacle in the bottom to hold asbestos waste. The glovebag is installed to surround the material to be removed and contain all fibers released through the process, with provisions for allowing continuous airflow through the bag while maintaining negative pressure inside.

FF. Owner Representative: Designated by the Owner, and/or designated employee(s) of the Owner Representative.

GG. PACM: Presumed asbestos-containing materials.

HH. Pressure Differential Fan System: An air-purifying fan system located inside or outside the isolated work area that draws air out of the work area through a HEPA filter, keeping static air pressure in the work area lower than in adjacent areas, and preventing escape of contaminated air from work area to adjacent areas.

II. Public Area: Any area outside the isolated work area. When work area isolation measures are removed, the work area becomes a public area.

JJ. Removal: All operations where ACM and/or PACM are taken out or stripped from structures or substrates, and include demolition activities.

KK. Shower Room: A room between the clean room and the equipment room in the worker decontamination enclosure system that is equipped with soap, shampoo, and hot and cold running water controllable at the faucet, and suitably arranged for complete showering during decontamination. The shower room must be separated from the clean room and equipment room by air locks.

LL. Special Fitting: With regard to pipe insulation, a special fitting is any valve, union, strainer, thermometer, flange, etc.

MM. Surfactant: A chemical wetting agent added to water to improve penetration, thus reducing the quantity of water required for a given operation or area.

NN. Tack Coat: A coat of penetrating encapsulant applied to all surfaces from which asbestos-containing materials have been removed.

OO. Thermal System Insulation (TSI): ACM applied to pipes, fittings, boilers, breeching, tanks, ducts, or other structural components to prevent heat loss or gain.

PP. Vacuum Loader Removal: Wetting and pneumatic conveying of loose material through a vacuum hose to a sealed collection tank specially equipped to prevent escape of fibers.

QQ. Wet Cleaning: The process of eliminating asbestos from building surfaces and objects by using cloths, mops, or other cleaning tools that have been dampened with water.

RR. Worker Decontamination Enclosure System: A showering facility for workers, typically consisting of a clean room, a shower room, and an equipment room. Each of these rooms is separated from the others by air locks. The equipment room is separated from the work area by a curtained doorway. The clean room is separated from the public area by a curtained doorway.

SS. Worksite Entry Logbook: A logbook kept in the clean room that must be signed by everyone entering or leaving the work area. All pages of the logbook must be the same as the sample page bound into these Specifications.

1.3 DOCUMENTS INCORPORATED BY REFERENCE

A. The current issue of each document shall govern. Where conflict among requirements or with these Specifications exists, the most stringent requirements shall apply.

1. US Environmental Protection Agency National Emissions Standards for Hazardous Air Pollutants (NESHAPS). (Code of Federal Regulations Title 40, Part 61, Subparts A and M.)

2. US Environmental Protection Agency Office of Toxic Substances Guidance Document, "Guidance for Controlling Friable Asbestos-Containing Materials in Buildings." EPA Report Number 560/5-85-024 ("Purple Book").
3. US Department of Labor Occupational Safety and Health Administration (OSHA):
    a. Title 29 Code of Federal Regulations Section 1910.1001—General Industry Standard for Asbestos.
    b. Title 29 Code of Federal Regulations Section 1910.134—General Industry Standard for Respiratory Protection.
    c. Title 29 Code of Federal Regulations Section 1910 et al.—Occupational Exposure to Asbestos; Final Rule.
    d. Title 29 Code of Federal Regulations 1926.1101—Construction Standard for Asbestos.
    e. Title 29 Code of Federal Regulations Section 1910.1020—Access to Employee Exposure and Medical Records.
    f. Title 29 Code of Federal Regulations Section 1910.1200—Hazard Communication.
4. National Institute for Occupational Safety and Health (NIOSH), 42 CFR, Part 84, Respiratory Protective Devices.
5. American National Standards Institute (ANSI) NY; ANSI Standard Z 88.2-1980 "American National Standards Practice for Respiratory Protection," latest edition.
6. Oregon Administrative Rules Chapter 340, Division 248, Department of Environmental Quality; Chapter 340, Division 33, Licensing and Certification Requirements.
7. Oregon Administrative Rules Chapter 437, Divisions 2 and 3.
8. Oregon Revised Statutes (ORS), Chapters 279C, Certified Asbestos Contractors and Prevailing Wage; 656, Workers Compensation; and 701, Construction Contractors and Contracts.
9. All related electrical work shall be performed in accordance with the National Electrical Code.
10. All local ordinances, regulations, or rules pertaining to asbestos, including its storage, transportation, and disposal.

1.4 SUBMITTALS AND NOTICES

A. Contractors shall submit three bound indexed copies of each submittal package as indicated below.

B. Contractors shall submit to the architect and environmental consultant the following information prior to beginning work on the project:

1. CONTRACTOR'S LICENSE. Submit proof that the asbestos abatement contractor is currently and for the duration of the project licensed in the state of Oregon to perform asbestos abatement, per ORS Chapter 701, and OAR Chapter 340, Division 248.
2. ASBESTOS SUPERVISOR. Submit the name and resume of the assigned on-site foreman. At minimum, the foreman shall have successfully completed the Department of Environmental Quality (DEQ) asbestos supervisor course as approved by the State of Oregon. Other criteria such as references and similar projects will also be reviewed. At the architect or environmental consultant's request, the contractor shall arrange an oral interview with the assigned on-site foreman. The owner, architect, and the environmental consultant reserve the right to reject the

foreman from the work at any time during the project. The contractor shall then assign another on-site foreman for the owner, architect, and environmental consultant's approval as described above.

3. INSURANCE CERTIFICATE. Submit a copy of the certificate of asbestos-specific liability insurance policy.
4. WORKER CERTIFICATION. Submit written proof indicating that all employees impacting asbestos-containing materials are Oregon state certified asbestos workers. Proof shall include photocopies of certificates and a signature from the contractor's principal indicating that all employees assigned to this project have completed such a program.
5. RESPIRATOR PROGRAM. Submit written proof indicating respirator program complies with all parts of OSHA Asbestos Regulations CFR Title 29, Part 1910.134 and 1926.1101, OR-OSHA Chapter 437, 1910.134 and 1926.1101.
6. MEDICAL PROGRAM. Submit written proof medical exam program complies with OSHA Asbestos Regulations CFR Title 29, Section 1926.1101 and OR-OSHA Chapter 437, 1926.1101.
7. EMERGENCY PLANS. Submit a written emergency control and cleanup plan to be followed by the contractor in the event of an accidental breach in containment, power failure, and accidental disturbance of ACMs in non-isolated areas.
8. NOTIFICATION. Submit copy of written notification to DEQ of the proposed asbestos work not fewer than 10 days before work commences on this project.
9. DISPOSAL PLAN. Submit written proof that all required permits and arrangements regarding the transportation and disposal of asbestos-containing or contaminated materials, supplies, etc. have been obtained. The disposal site must be approved by the EPA and/or DEQ and other responsible agencies.
10. WORK PLAN. Submit a written "work plan" satisfactory to the architect and environmental consultant describing the schedule for asbestos abatement, decontamination procedures, and plans for construction and location of decontamination enclosure systems, pressure differential exhaust fans, etc. in compliance with these Specifications and applicable regulations, including calculations for determining required number of negative-air filtration units. The plan shall schedule the systematic flow of work throughout the facility per Specifications on a day-by- day basis, outlining room-by-room, or area-by-area procedures and planned alternative control measures. The contractor shall keep close coordination of his work with the architect and environmental consultant.
11. AIR MONITORING. Submit information pertaining to the proposed Air Monitoring Program for this project, if appropriate. This information shall include the name(s) of the certified industrial hygienist appointed, the name of the on-site industrial hygiene technician working under his supervision, types of equipment, and sampling schedule, sampling procedures, calibration recordkeeping, and testing laboratory proposed.
12. PRODUCT INFORMATION. Submit complete product information for any materials and products for which the contractor requests approval for use on this job (other than those specified).
13. EMERGENCY PHONE NUMBER. Submit a local phone number at which the contractor or on-site foreman can be reached on a 24-hour basis during the course of the work.

C. Contractor shall not begin work until submittals are reviewed and accepted by architect and the environmental consultant. Allow a ten-day review period.

D. During the work, the contractor shall submit the following to the architect and environmental consultant, on a periodic basis as agreed to by the architect, environmental consultant, and contractor:

1. Waste shipment and disposal documentation.
2. Air monitoring data.
3. Notification updates.

E. Contractor shall submit to the environmental consultant, in writing, all information required above regarding any new asbestos workers hired by, or subcontracted to, the contractor before these new asbestos abatement workers begin work.

F. Prior to removal of decontamination systems and isolation barriers, the contractor shall obtain specific written permission from the environmental consultant.

G. Prior to making final application for payment the contractor shall:

1. Complete all work under this contract.
2. Submit to the environmental consultant all required submittals, including all waste shipment records completely filled out and signed.
3. Submit to the owner all payroll reports for work on this contract and other information as described elsewhere in the Specifications, if appropriate, under the contract.
4. Submit to the environmental consultant "as-abated" drawings along with a signed affidavit stating that all asbestos-containing materials have been removed as indicated on the drawings.

H. See other sections of these Specifications, and EPA, OSHA, and other standards referenced therein, for further information and requirements not included above.

1.5 BUILDING PROTECTION

A. Building Security and Protection

1. The contractor shall post adequate warning signs at all potential entrances to work areas as required by EPA and OSHA.
2. The contractor shall protect all existing fixed equipment, building finishes that are to remain, and existing systems and functions from damage during the abatement process. Extra precautions are to be taken in protecting existing electrical panels, light fixtures, etc. Any damage to existing building, services, and/or equipment shall be remedied by the contractor at their expense.
3. Contractor shall clean external surfaces of contaminated containers and equipment thoroughly by wet sponging and HEPA vacuum.
4. Contractor shall maintain access and use of existing fire lanes.

1.6 PERSONAL PROTECTION

A. Training

1. Prior to commencement of work, contractor shall ensure all workers have been trained as specified.
2. The contractor shall provide and post, in the clean room(s) and the equipment room(s), the decontamination, respirator, and work procedures to be followed by the workers.

B. Personnel Personal Protective Equipment for Asbestos Removal

1. Work clothes shall consist of disposable full-body coveralls and head and foot covers ("Tyvek" or approved), boots, or sneakers. Eye, hearing, fall protection, and hard hats should be available as appropriate.

2. At minimum, respiratory protection shall be approved by National Institute for Occupational Safety and Health/Mine Safety and Health Administration (NIOSH/MSHA); US Department of Labor; US Department of Health, Education, and Welfare; Centers for Disease Control; and as listed below. Respiratory protection shall provide workers with a maximum calculated fiber level inside the mask of 0.01 f/cc.

    a. Glovebag or modified glovebag: full-face mask, powered air-purifying respirator with disposable HEPA filter cartridges (magenta/purple color code). Protection factor: 100.

    b. Demolition of walls and ceilings that may impact friable asbestos-containing material: half-face mask, negative-pressure respirator with disposable HEPA filter cartridges (magenta/purple color code). Protection factor: 10.

    c. Pre-abatement work in close proximity to friable asbestos-containing materials: half-face mask, negative-pressure respirator with disposable HEPA filter cartridges (magenta/purple color code). Protection factor: 10.

    d. Abatement in isolated areas: full-face mask, powered air-purifying respirator with disposable HEPA filter cartridges (magenta/purple color code). Protection factor: 100.

    e. HEPA vacuuming and wet cleaning of surfaces: half-face mask, negative-pressure respirator with disposable HEPA filter cartridges (magenta/purple color code). Protection factor: 10.

    f. Vinyl asbestos floor tile removal: half-face mask, negative-pressure respirator with disposable HEPA filter cartridges (magenta/purple color code). Protection factor: 10.

    g. Handling of double-bagged asbestos-contaminated waste: half-face mask, negative-pressure respirator with disposable HEPA filter cartridges (magenta/purple color code). Protection factor: 10.

3. Additional respiratory protection shall be as required by CFR 29 1910.134 and 1926.1101, OR-OSHA Chapter 437, 1910.134 and 1926.1101.

4. As part of the Contractor's Respiratory Protection Program, all workers shall be provided with a selection of brands and sizes of respirators to choose from. At a minimum, all workers shall be qualitatively fit-tested at the time of respirator selection per OR-OSHA Worker's Compensation Department Rule 22-069 (4)(e)(5)(i), and semiannually thereafter.

5. Contractor shall supply replacement filter cartridges, as required. Cartridges that have become wet or clogged shall be replaced immediately.

C. Worker Decontamination Enclosure System

1. The contractor shall construct a personnel decontamination facility immediately outside of the isolated work area consisting of three chambers and two air locks as follows:

    a. The equipment room shall consist of an air lock to the shower room, and a curtained doorway to the work area.

b. The shower room shall have two air locks, one to the equipment room and one to the clean room. All showers shall have hot and cold water controllable at the taps and installed in this room. The contractor shall supply and maintain soap, shampoo, and towels at all times in the shower area. Shower wastewater shall be filtered to remove all fibers larger than five microns, or as required by local regulations, before disposal in the municipal sewer system, or shall be collected and disposed of as asbestos-contaminated material. Permits shall be obtained and all water discharge regulations complied with, as required by local municipalities. Water filters shall be disposed of as asbestos-contaminated material.

c. The clean room shall consist of an air lock to the shower room and a curtained doorway to the adjacent building area. The clean room shall contain a first aid kit, a place to sit down, the Worksite Entry Logbook, and storage for workers' and visitors' clothing and shoes. Work, respirator, and decontamination procedures; regulations; and prevailing wage rates shall be conspicuously posted. There shall be a supply of clean, protective clothing, and respirators and cartridges in the clean room at all times.

d. A monometer measuring pressure differential within and outside the containment shall be installed and remain operable on any containment from the start of abatement work until work is complete, and satisfactory clearance results are obtained. Air pressure within the containment shall remain at or below -0.02 inches of water (compared to ambient air pressure) throughout.

2. Contractor shall not begin asbestos abatement work unless this system is functional, in good repair, and has been found acceptable for specification compliance by the environmental consultant.

D. Personnel Protection Procedures in Isolated Work Areas

1. Each worker shall, upon entering the jobsite, remove street clothes in the clean change room, put on and fit-test their respirator, put on clean protective clothing, and sign in on the Worksite Entry Logbook before entering the equipment room or the work area.

2. Workers shall, each time they leave the work area, remove gross contamination from clothing before leaving the work area; proceed to the equipment room and remove and dispose of disposable work clothes; remove and store shoes, boots, and other equipment except respirators; still wearing the respirator, proceed to the showers and clean the outside of the respirator with soap and water while showering; remove the respirator; thoroughly shampoo and wash themselves; remove filters, dispose of filters in the container provided for that purpose, and wash and rinse the inside of the respirator.

3. Following showering and drying off, each worker shall proceed directly to the clean change room and dress in clean clothes at the end of each day's work or before eating, smoking, or drinking. Before reentering the work area from the clean change room, each worker shall put on his respirator with clean filters, dress in clean protective clothing, and sign in on the Worksite Entry Logbook.

4. Contaminated work footwear and other equipment shall be stored in the equipment room when not in use in the work area. Upon completion of asbestos abatement, footwear shall be disposed of as contaminated waste or cleaned thoroughly inside and out, using soap and water, before removing from work area.

5. Workers shall not eat, drink, or chew gum at the worksite except in the established clean room. Smoking or using other tobacco products is prohibited.
6. Workers shall be fully protected with respirators and protective clothing immediately prior to the first disturbance of asbestos-containing or contaminated material and until final cleanup is completed.

E. Access to Isolated Work Area by Others

1. Except for emergency personnel, the contractor shall limit access to the work area to authorized visitors.
2. The contractor shall provide protective clothing, respirators, and equipment for all authorized visitors, as specified above.
3. All authorized visitors shall be subject to the personnel protection provisions specified above, and shall sign in and out on the Worksite Entry Logbook.

F. Personal Protection during Work in Non-Isolated Work Areas:

1. Work clothes per Section 1.06 B.
2. Respiratory protection per Section 1.06 B.
3. Worker protection procedures will differ from Section 1.06 D, in that two layers of coveralls shall be worn after removal of street clothes. Worker decontamination through a Worker decontamination enclosure is required. The first layer of coveralls must be removed when exiting the glovebag work area. The worker shall immediately proceed to the worker decontamination unit. The remaining requirements of Section 1.06 D still apply.
4. Contractor shall submit to the architect and environmental consultant for approval an emergency control and cleanup plan to be followed in the event of asbestos contamination during glovebag use. Contractor shall ensure all workers are thoroughly familiar with approved plan.
5. Contractor shall promptly remove all bags as they are used to the bag-holding and decontamination enclosure system.

G. Emergency Precautions

1. The contractor shall establish emergency and fire exits from the work area. Contractor shall ensure these exits are well marked and remain unobstructed.
2. The contractor shall be prepared to administer first aid to injured personnel after decontamination. Seriously injured personnel shall be treated immediately or evacuated without delay for decontamination.
3. Contractor shall notify the local fire department of the asbestos abatement project prior to beginning work area preparation.

1.7 SAFETY

With regard to the work of this contract, the safety of the contractor's employees, the owner's employees, and the public is the sole responsibility of the contractor.

1.8 LIABILITY

The contractor is an independent contractor and not an employee of the owner, architect, or the environmental consultant. The owner, architect, and environmental consultant shall have no liability to the

contractor, or any third persons, for contractor's failure to faithfully perform and follow the provisions of these Specifications and the requirements of the governing agencies. Notwithstanding the failure of the owner, architect, or the environmental consultant to discover a violation by the contractor of any of the provisions of these Specifications, or to require the contractor to fully perform and follow any of them, shall not constitute a waiver of any of the requirements of these Specifications, which shall remain fully binding upon the contractor.

1.9 DELIVERY

Contractor shall deliver all materials to the worksite in the original packages, containers or bundles bearing the name of the manufacturer and the brand name.

1.10 STORAGE

Contractor shall store all materials subject to damage off the ground, away from wet or damp surfaces, away from heat sources, and under cover sufficient to prevent damage, contamination, or fire.

1.11 PROTECTION

Damaged or deteriorating materials shall not be used and shall be removed from the premises by the contractor. Materials that become contaminated with asbestos shall be disposed of in accordance with the applicable regulations by the contractor.

1.12 SUBCONTRACTORS

Any subcontractors employed by the contractor shall be bound to all the work and safety standards specified elsewhere in this Specification. Subcontractor's personnel shall be fully trained and supervised by the contractor during performance of this work.

1.13 AIR MONITORING BY ABATEMENT CONTRACTOR

A. An Independent Testing Laboratory shall be retained by the Abatement Contractor. All air-monitoring analysis shall be performed by an Industrial Hygienist. The Industrial Hygienist must be experienced and trained in asbestos sampling and analysis. At a minimum, documentation of prior asbestos sampling and analysis experience, plus satisfactory completion of the NIOSH 582 course or equivalent formal asbestos education, will be required. The laboratory must meet the requirements specified in Section 02 82 13. Air sample collection may be performed by an Industrial Hygienist or the Abatement Contractor's foreman at the Abatement Contractor's option.

B. Documentation shall be kept for each filter sample procured as to worker sampled, work area location, date, and time taken, volume of air drawn through filter, pump identification number and calibration. Documentation shall indicate in what areas tests were taken and shall clearly indicate the specified maximum allowable fiber levels for each area tested. Submit chain-of-custody records along with all samples.

C. The samples shall be collected on 25 millimeter (mm) filters and analyzed within 12 hours using the membrane filter method at 400-500x magnification with phase contrast illumination - NIOSH Analytical Method No. 7400 - for laboratory and field analysis. The analyst shall sign and submit permanent records of all samples analyzed directly to the Environmental Consultant. The Independent Testing Laboratory shall seal the unused portion of all filters in airtight containers so that individual samples can be reanalyzed at a later date if necessary. The containers shall be clearly labeled with project name and sample number and shall become property of the Owner at work completion at the Owner's request.

D. The Abatement Contractor's testing laboratory shall submit sample analysis results to the Environmental Consultant verbally within 18 hours from the time of collection and written within two weeks including chain-of-custody and equipment calibration records.

E. Abatement Contractor's Sampling During Abatement:

1. Air monitoring shall be performed to provide samples during the period of asbestos abatement in each work area. Begin sampling when asbestos removal commences. Samples are to be taken where Class I or II work is being conducted during each 8-hour work shift until abatement is complete in that work area or until a negative exposure assessment is established per 29 CFR 1926.1101.

2. The Abatement Contractor shall determine which worker(s) in each work area is probably experiencing the most severe exposure. This is the "Most Contaminated Worker(s)". Eight (8)-hour TWA and 30-minute excursion samples shall be collected on this worker(s). This worker shall wear a personal sampling pump and the sample shall be drawn from the breathing zone of this worker. All other samples are area samples.

3. The number of air samples collected shall be determined by the Abatement Contractor, and may be altered during the project based on work activity and results.

4. The maximum allowable fiber levels shall be as determined by the Environmental Consultant based on the respiratory protection being utilized.

F. Abatement Contractor shall notify the Department of Environmental Quality of air monitoring clearance results as supplied by Environmental Consultant. Notification shall be within 30 days after monitoring procedures were performed in accordance to OAR 340-32-465.

1.14 AIR MONITORING BY OWNER

A. The Owner will retain an experienced Industrial Hygienist/Environmental Consultant to collect and analyze asbestos air samples. Documentation of sample results will be forwarded to the Abatement Contractor as appropriate to regulatory requirements.

B. Samples analyzed by phase contrast microscopy (PCM) will use NIOSH Analytical Method No. 7400. Samples analyzed by transmission electron microscopy (TEM) will use either the AHERA methodology, 40 CFR Part 763, or Yamate Level Two.

C. Owner's Air Sampling During and After Abatement:

1. Air Sampling Table is to be used as a guide. The Owner's Industrial Hygienist/Environmental Consultant may modify criteria. Modifications to the Maximum Allowable Fiber Count shall be made in writing by the Owner.

Type of Sample	Average Samples per 8-hour Work Shift	Sample Volume--L (Liters [L])	Approximate Flow Rate	Maximum Allowable Fiber Count (f/cc)
HEPA Fan Exhaust	0 or selected units	400-2000 L	2 to 10 LPM	0.01 f/cc
Outside of Work Area	0-5	400-2000 L	2 to 10 LPM	0.01 f/cc or <pre-abatement
Clearance PCM	1-5/work area	800-3000 L	2 to 10 LPM	0.01 f/cc
Clearance TEM	1-5/work area	1200-1800 L	2 to 10 LPM	<70 s/mm^2 average

LPM = liters per minute
f/cc = fibers per cubic centimeter
s/mm^2 = structures per millimeters squared

2. Air sampling for post-abatement work in isolated work areas will use the aggressive sampling method. Use of aggressive sampling in other areas shall be as directed by the Environmental Consultant. Aggressive sampling shall be conducted to assure that fibers remain airborne during sample collection.

3. Analysis of all clearance samples shall be via PCM.

4. The Abatement Contractor shall allow 48 hours for the collection and analysis of final PCM air clearance samples. In addition, the Abatement Contractor must provide at least 24 hours advance notice to the Environmental Consultant for final visual Inspection and clearance air monitoring.

5. The Owner reserves the right to monitor Abatement Contractor's performance via air samples on abatement workers and in the work area in addition to the Abatement Contractor's air monitoring.

1.15 QUALITY ASSURANCE

A. If, at any time during the work, analysis of an air sample taken by the Abatement Contractor, Owner, or Owner's representative, indicates a fiber count in excess of the allowable maximums specified, the Industrial Hygienist who analyzed the air sample shall immediately notify:

1. The Abatement Contractor's Foreman

2. The Environmental Consultant: PBS Engineering and Environmental Inc.

3. Other workers, employees, occupants, etc. in affected area(s).

B. Immediately upon being notified of fiber count exceeding the specified maximum allowable levels, the Abatement Contractor shall perform the following steps in the order presented, at no additional cost to the Owner:

1. Stop abatement work.

2. Identify source of high fiber counts.

3. Immediately correct any containment breaches, pressure differential changes or other potential cause, and other concerns with the Environmental Consultant, and the Owner, if the Owner is available. The Environmental Consultant will determine the affected area and affected adjacent areas considered to be contaminated. The Environmental Consultant will determine the actions to be taken by the Abatement Contractor at no additional cost to the Owner.

a. Clean the affected area and the affected adjacent areas. Cleaning shall use wet methods and HEPA vacuuming.

b. Resample air until fiber counts are determined to be below one half of the specified maximum levels.

c. Secure and repair containment barriers, repair or add equipment.

d. Modify work procedures, and make other changes determined to be the possible cause of high fiber counts.

4. Carefully resume work under close air monitoring.

5. The Abatement Contractor shall be responsible for costs of any testing, cleanup, repair, down time loss, etc. that is a result of the Abatement Contractor's negligence, poor maintenance of isolated areas or improper procedures.

PART 2 PRODUCTS

2.1 MATERIALS

A. Plastic Sheet: Plastic sheet shall be flame-retardant polyethylene material sized in lengths and widths to minimize the frequency of joints. The minimum thickness shall be 6-mil.

B. Plastic Bags: Plastic bags shall be 6-mil polyethylene printed with warning labels per OSHA and EPA regulations.

C. Tape: Tape shall be capable of sealing joints of adjacent sheets of plastic; attaching plastic sheet to finished or unfinished surfaces of dissimilar materials; and adhering under dry and wet conditions, including use of amended water. Minimum of 2-inch-wide tape must be used.

D. Disposal Containers: Disposal containers shall be suitable to receive and retain any asbestos-containing or contaminated materials until disposal at an approved site. The containers shall be labeled in accordance with OSHA and EPA regulations. Containers must be both airtight and watertight, and have hard top, bottom, and sides.

E. Warning Labels and Signs: Warning labels and signs shall be posted as required by OR-OSHA, ODOT, and DEQ regulations.

F. Amended Water: Clean potable water containing a surfactant additive. The surfactant additive shall be 50 percent polyoxyethylene ether and 50 percent polyethylene ester, or equivalent, and shall be mixed with water at a concentration of one ounce surfactant to five gallons of water, or as recommended by the manufacturer in the case of an equivalent.

G. Encapsulants (Sealants): Encapsulants shall be of the bridging or penetrating variety and shall be listed as "satisfactory" by the EPA. Encapsulants shall provide a suitable substrate bonding agent for application of new material where appropriate. Penetrating Encapsulant: No. 207 Special Sealer #33775-27A as manufactured by Makus-Cincinnatus, Inc.; "Asbestop 30B-2" as manufactured by Asbesco Corp.; "Cable Coating 22-P" as manufactured by American Coatings Corp., or approved. Bridging Encapsulant: Decadex Firecheck, manufacturer's standard color "Magnolia," as manufactured by Pentagon Plastics, Inc.; "Cable Coating 2-B," manufacturer's standard color gray, as manufactured by American Coatings Corp.; or approved.

H. Rewettable Lagging Cloth: Twelve ounce glass fabric lagging cloth saturated with dried lagging adhesive. "Dip-Lag" as manufactured by Claremont Co. or approved.

I. Enclosure: Protective plastic jacketing systems, framed gypsum board enclosures, suspended ceilings or other materials as specified elsewhere.

J. Other Materials: Provide all other materials such as lumber, nails, and hardware, which may be required to construct and dismantle the decontamination area, and the barriers that isolate the work area, and as required to complete the work, as specified.

2.2 TOOLS AND EQUIPMENT

A. Water Sprayer: The water sprayer shall be an airless or other low-pressure sprayer for amended water application.

B. Air-Purifying Equipment: Air-purifying equipment shall consist of high-efficiency particulate air (HEPA) filtration systems. No air movement system or air equipment shall discharge asbestos fibers outside the work area. Each unit shall be capable of variable volume from a minimum of 500 cubic feet per minute (CFM) to at least 1700 CFM under load and shall have at least two stages of pre-filtration ahead of the HEPA final filter. Each unit shall be overload protected, and equipped with an elapsed time indicator (hour meter), static pressure gauge with low flow alarm, and heat and smoke sensors that visually and audibly warn workers and shut unit fan down within 30 seconds. The units shall be: Micro-Trap Portable Air Filtration System manufactured by Asbestos Control Technology, Inc., "HOG 2000" Negative-air Protection System manufactured by Control Resource Systems, or approved.

C. Pressure Differential Monitoring Equipment: A combination sensing, alarm, and recording device shall be in operation at all times during use of the HEPA air-purifying equipment. The unit shall be a "Neg-A-Master," manufactured by Control Resource Systems, Inc., or approved.

D. Water-purifying Equipment: Water-purifying equipment shall be capable of removing all fibers longer than five microns, or as required by local regulations, from water used in abatement work and decontamination showers. Control Resource Systems, Inc. "AQUA-HOG" or approved.

E. Airless Sprayer: An airless sprayer, suitable for application of penetrating encapsulant material, shall be used.

F. Vacuum Equipment: All vacuum equipment used in the work area shall be High-efficiency Particulate Air (HEPA) equipment, and suitable for wet/dry usage.

G. Scaffolding: Scaffolding, as required to accomplish the specified work, shall meet all applicable safety regulations. All special scaffolding shall have drawings and calculations stamped and signed by a civil or structural engineer registered in the state of Oregon.

H. Transportation Equipment: Transportation equipment, as required, shall be suitable for loading, temporary storage, transit, and unloading of contaminated waste without exposure to persons or property. Equipment shall have a hard top, bottom, and sides. If equipment is rented, notify rental agency in advance, in writing, of intended use of equipment.

I. Electrical: Electrical tools, equipment, and lighting shall meet all applicable codes and regulations. Ground fault protection as required by OSHA, shall be in effect at all times. Contractor shall take all additional precautions and measures necessary to ensure a safe working environment during wet removal.

J. Glovebags: Bags shall be clean poly bags seamless at the bottom, with pre-printed asbestos warning labels, 6-mil PVC with attached TYVEK arms, and latex gloves. Bags shall be Profo' Bag manufactured by Asbestos Control Technology, Inc., or Asbest'O'Saf/SAC by Control Resource Systems, Inc., or approved.

K. Remote Filter Housing: Stainless steel housing shall have pre-filters and HEPA filter sealed to cabinet flanges by Century Equipment "Advance Guard II" or approved equal.

L. Other Tools and Equipment: Other suitable tools shall be provided for the removal, enclosure, encapsulation, patching, and disposal activities including, but not limited to, hand-held scrapers, wire brushes, sponges, and rounded-edge shovels.

PART 3 EXECUTION

3.1 FULL ISOLATION WORK AREA PREPARATION

A. Contractor shall perform the following isolation procedures in the order in which they are presented. Any alternative control measures considered for Class I/II work shall be performed in accordance with 29 CFR 1926.1101.

1. Shut down, remove filters, and isolate HVAC systems to prevent contamination and fiber dispersal. Coordinate with building users and CMGC prior to shutdown.

2. Coordinate all electrical, safety, and other service connections, requirements and equipment with the CMGC. Use a journeyman electrician at a minimum. It is the contractor's responsibility to verify operation of systems that will be shut off during abatement. If any system is found to be defective or not operating satisfactorily, the contractor shall notify the CMGC or environmental consultant in writing prior to shutoff.

3. Install critical barriers as follows: seal off all openings including, but not limited to, doorways, windows, and other penetrations of the work area with solid critical barriers except openings left for HEPA air-purification system, which shall be properly HEPA-filtered. Where doors exist, sealing may be done by closing door, sealing with tape on both sides, and then covering both sides with two layers of plastic sheeting.

4. Pre-clean movable objects, such as furniture and equipment to be removed (and carpeting), within the proposed work areas using HEPA-filtered vacuum equipment and/or wet cleaning methods as appropriate, and remove such objects from work areas to a temporary location, or consolidate such objects away from removal work and enclose with critical barriers.

5. Pre-clean fixed objects within the proposed work areas using HEPA-filtered vacuum equipment and/or wet cleaning methods as appropriate, and enclose with critical barriers. Equipment that must continue operating shall be enclosed and ventilated to avoid damage.
6. Set up the worker decontamination enclosure system (decon). Once this system is installed and abatement commences, it shall be used in the specified manner for the ingress and egress of all personnel and equipment, except in emergency situations. All personnel shall sign the Worksite Entry Logbook each time they pass in or out of the decontamination enclosure.
7. Install HEPA air-purifying equipment pressure differential fan system so as to ensure lower static pressure in the isolated work area than in surrounding areas, a flow of air through all parts of the isolated work area towards the air-purifying equipment, and minimum air contamination levels at abatement worker breathing zones. Discharge from air-purifying equipment shall be ducted outside the building. Use one or more units of capacity as recommended by the manufacturer for the volume of the isolated work area, but in no case shall airflow be less than six air changes every 60 minutes with a minimum pressure differential of 0.02 inches wg between the work area and the decon clean room.
8. Cover floor and wall surfaces with plastic sheeting sealed with tape. Cover floors first so that plastic extends at least 12 inches up on walls, then cover walls with plastic sheeting to overlap floor plastic by a minimum of 24 inches, thus overlapping the horizontal floor material by a minimum of 12 inches. Install additional layer of plastic sheeting on floor and walls in similar manner. Contractor may use mechanical fastening techniques, such as tack strips, as necessary to secure wall plastic sheeting. Contractor shall repair any damage resulting from mechanical fasteners.
9. Maintain emergency and fire exits from the work areas, or establish alternative exits satisfactory to the local building or fire department officials. Ensure that all exits remain unobstructed and well marked.
10. Adequate portable fire extinguishing equipment shall be maintained within work area as defined by OSHA and/or local fire department officials.

B. No asbestos abatement work shall occur unless the work area isolation has been found acceptable for Specification compliance by the environmental consultant.

C. Isolated work area enclosure system maintenance. The contractor shall be responsible for daily documentation of the following:

1. Prior to the first use, and at the beginning of each shift during abatement work, containments shall be given a complete visual inspection by the contractor's shift foreman and industrial hygienist. Inspection shall include the HEPA air-purification system and associated filters. A smoke tube test by the shift foreman shall then be made of the worker decontamination enclosure system and other critical areas to verify that the isolated area is under negative air pressure. Work shall not begin until all defects have been repaired.
2. Periodic inspections shall be made, as required, during each shift to assure continued proper functioning of the containment and HEPA system.

3.2 NON-ISOLATED WORK AREA PREPARATION

A. Contractor shall perform the following procedures in the order in which they are presented and describe procedures for glovebag work and other work in non-isolated work areas. Any alternative

control measures considered for Class II work shall be performed in accordance with 29 CFR 1926.1101.

1. Shut down heating, ventilation, and air conditioning (HVAC) systems. Coordinate with building users and the CMGC prior to shutdown.
2. Restrict access to work area and post warning signs. Do not perform glovebag work or any abatement work in an occupied area.
3. Completely pre-clean entire work area using HEPA vacuum equipment or wet cleaning methods.
4. Set up the worker decontamination enclosure system. Once this system is installed and abatement commences, it shall be used in the specified manner for the ingress and egress of all personnel, except in emergency situations. All personnel shall sign the Worksite Entry Logbook each time they pass in or out of the decontamination enclosure.
5. At the direction of the environmental consultant, install HEPA exhaust fan in work area. Duct fan intake to immediate area of work in such a manner that any fibers released will be drawn away from the worker and into intake duct.
6. Cover floor and other surfaces below work area with 6-mil plastic sheeting. Seal openings and install curtained doorways and air locks as directed by the environmental consultant.
7. Have emergency cleanup equipment and supplies, including HEPA vacuum, amended water, disposal bags, mop, buckets, towels, and sponges on hand prior to start of abatement work.

B. No asbestos abatement work shall occur unless the work area has been found acceptable for Specification compliance by the environmental consultant or industrial hygiene technician.

3.3 REMOVAL OF ASBESTOS-CONTAINING MATERIALS IN FULL ISOLATION WORK AREAS

A. Contractor shall isolate work area as specified.

B. Remove all asbestos-containing vinyl floor tile as Class 1 friable asbestos removal.

1. Contractor shall spray the asbestos material with amended water. A fine spray of this solution shall be applied to prevent fiber disturbance preceding the removal of the asbestos material. The asbestos shall be sufficiently saturated to prevent emission of airborne fibers in excess of specified fiber levels.
2. Contractor shall remove asbestos material while damp and pack it in sealable containers. Containers shall be moved to bag load out facility or equipment room in the worker decontamination system.
3. Contractor shall collect all water used in the removal and cleaning process and dispose of as contaminated waste or filter to remove all fibers more than five microns in length before disposal in the municipal sewer system, or as required by local regulations. Water filters shall be disposed of as asbestos-contaminated material.

C. All wooden subfloor associated with asbestos-containing mastic shall be wholly removed and disposed of as asbestos waste in accordance with section 3.9, Disposal.

D. Contractor shall maintain a safe and uncluttered work area, worker decontamination system, and bag load out facility on a daily basis.

3.4 REMOVAL OF ASBESTOS-CONTAINING MATERIALS IN NON-ISOLATED AREAS

A. Contractor shall apply spray coat of amended water to material to be removed; material shall be kept damp during entire removal process.

B. Glovebag work shall be as follows. All removal using the glovebag method shall be performed strictly according to regulations, manufacturer's printed instructions, and as demonstrated by the manufacturer's representative or as further specified in this section. Workers are not to smoke or wear hand or wrist jewelry while using glovebags.

1. Contractor shall install port for hose of HEPA vacuum to create reduced pressure inside glovebag. Installing of fresh air intake and/or bridging to prevent collapse of bag are acceptable. Reduced pressure shall be maintained throughout entire abatement procedure.

2. During the removal phase, contractor shall use amended water to reduce potential for airborne fibers.

3. Contractor shall seal flap if used and, using a HEPA vacuum, remove all contaminated air in the upper chamber.

4. Contractor shall promptly double-bag the glovebag after removal is complete, place it into a sealed container, and remove to the bag holding enclosure.

C. Exterior door and window caulking shall be removed using the following methods:

1. Caulking shall be removed in a non-friable state. Caulking that is determined to be friable or which is rendered friable during the abatement process shall be removed using either containment or glovebag methods.

2. The contractor shall utilize wet methods during removal and packaging for disposal.

3. The contractor may utilize a heat gun if at any time the caulking has the potential to become friable during removal.

4. The contractor shall have HEPA vacuums available and shall use them during removal.

5. The use of abrasive or mechanical methods to remove the caulking is prohibited.

6. Burning or blistering of the caulk with excessive heat by the heat gun is prohibited.

7. All asbestos-containing caulk and building components with residual asbestos caulk shall be disposed of as asbestos-containing waste as specified below.

3.5 CLEANUP IN FULL ISOLATION WORK AREAS

A. At the conclusion of removal in the isolated work area, conduct cleanup in the sequence described below. Windows, doors, HVAC vents, etc. shall remain sealed and HEPA-filtered pressure differential fan systems shall remain in service.

1. REMOVE MATERIAL AND EQUIPMENT. Contractor shall remove visible accumulations of material and debris (including filters removed from HVAC equipment and HEPA air-purification equipment). Contractor shall include all sealed containers and equipment used in the work area in the cleanup, and remove them from work area after decontamination of outer surfaces.

2. FIRST CLEAN. Contractor shall clean all surfaces in the work area and any other contaminated areas with water and/or with HEPA-filtered vacuum equipment.

3. WAIT 24 HOURS. After the first cleaning of the work area, wait 24 hours to allow for settlement of dust. During this settling period, no entry to the work area shall be allowed.

4. SECOND CLEAN. Wet-clean or clean with HEPA-filtered vacuum equipment all surfaces in the work area. After completion of the second cleaning operation, perform a complete visual inspection of the work area to ensure that the work area is free of visible debris.
5. VISUAL INSPECTION. Prior to application of post-removal encapsulant, contact the environmental consultant for a visual observation of the work area. The work area shall be free of visible debris. Observation by the consultant does not alleviate the contractor of responsibility to provide work in compliance with Specifications. Contractor shall contact environmental consultant at least 24 hours prior to desired inspection time.
6. REMOVE PLASTIC SHEETING. After visual observation by the consultant, contractor shall apply a coat of approved encapsulant to all surfaces in the work area where asbestos has been removed and to disposable plastic sheeting as a post-removal encapsulant. Encapsulant application shall follow all applicable manufacturer's recommendations and shall provide a compatible bonding agent for application of new material.
7. FINAL CLEAN. After the encapsulation is complete, the contractor shall remove all noncritical plastic and clean all floors, walls, fixtures, and other surfaces within the work area with only critical barriers in place using wet methods or HEPA-filtered vacuum equipment. Plastic sheeting over carpets may remain in place.
8. CONTACT ENVIRONMENTAL CONSULTANT. Contact the environmental consultant for a visual observation of the work area. The work area shall be free of visible debris. Observation by the consultant does not alleviate the contractor of responsibility to provide work in compliance with Specifications. Contractor shall contact environmental consultant at least 24 hours prior to desired inspection time. Consultant shall conduct final air monitoring as specified after work area has been allowed sufficient time to dry.
9. TEARDOWN. When the final observation by the environmental consultant and air sampling test results are satisfactory, the contractor shall then remove the decontamination systems and remaining barriers.
10. DISPOSAL. Contractor shall properly dispose of all waste materials. All polyethylene material, tape, cleaning material, and contaminated clothing shall be double-bagged, sealed, and labeled as described above for asbestos waste material.

3.6 CLEANUP IN NON-ISOLATED WORK AREAS

A. FIRST CLEAN. Contractor shall remove visible accumulations of asbestos material and debris. All surfaces shall be cleaned within the affected work area. Cleaning shall be with amended water and/or HEPA-filtered vacuum equipment. In a large open area, the affected work area shall include the immediate work area and an area that encompasses at least 6 feet in all directions or as defined by the environmental consultant. In small work areas, the affected work area shall include the entire room.

B. AFFECTED AREA. The affected work area may be further defined in the scope of work by the environmental consultant. During the work, high fiber levels, as indicated by air monitoring results, may increase the area to be cleaned. The increase in the affected area due to high fiber levels or other indications of fiber dispersal will be defined by the environmental consultant, and the contractor shall bear all costs of additional cleaning.

C. VISUAL INSPECTION. After completion of the cleaning operation, the environmental consultant shall perform a visual observation of the affected work area to ensure that the affected work area is free of

visible dust and debris. Observation by the consultant does not alleviate the contractor of responsibility to provide work in compliance with Specifications. Contractor shall contact environmental consultant at least 24 hours prior to desired inspection time.

D. ENCAPSULANT. After visual observation by the environmental consultant, contractor shall spray-apply encapsulant to the material substrate, all temporary plastic sheeting, and other temporary protective materials.

E. CLEARANCE SAMPLING. Post-abatement air sampling shall be at the discretion of the Environmental Consultant and will be determined by the ongoing sample results.

F. TEARDOWN. When the final observation by the environmental consultant and air sampling test results (if required) are satisfactory, the temporary plastic sheeting and other temporary protective materials shall be removed by the contractor.

G. DISPOSAL. Contractor shall properly dispose of all waste materials, all polyethylene material, tape, and cleaning material, and contaminated clothing shall be double-bagged, sealed, and labeled as described for asbestos waste material.

3.7 RE-ESTABLISHMENT OF OBJECTS AND SYSTEMS

A. When cleanup is complete, contractor shall:

1. Relocate objects moved to temporary locations in the course of the work to their former positions. Coordinate with the CMGC.

2. Clean, repair and/or repaint all surfaces soiled, discolored, or damaged by removal of tape, adhesive, or other work of this contract to match existing surfaces. The contractor shall bear all costs associated with damage incurred during the abatement, which includes, but is not limited to, perimeter plaster walls, wall murals, windows, and mullions

3. If the contractor uses caulking to seal cracks in concrete floor, the caulking must be removed to architect's satisfaction at completion of project.

4. Return mechanical, electrical, and other systems shut down by the contractor to complete and functional operation.

5. Re-secure objects removed in the course of work in their former positions, including air dampers in plenums, and adjust for proper operation.

6. Clean, repair and/or repaint all surfaces soiled, discolored, or damaged by removal of tape, adhesive, or other work of this contract to match adjacent surfaces.

3.8 DISPOSAL

A. Contractor shall affix warning labels having waterproof print and permanent adhesive to the lid and sides of all containers. Warning labels shall be conspicuous and legible, and contain the following words:

DANGER
CONTAINS ASBESTOS FIBERS
AVOID CREATING DUST
CANCER AND LUNG DISEASE HAZARD
AVOID BREATHING AIRBORNE ASBESTOS FIBERS

B. The contractor shall determine current waste handling, transportation, and disposal regulations for the work site and for each waste disposal landfill. The contractor must comply with these regulations and all US Department of Transportation, DEQ, and EPA requirements. Double-bagged material in containers shall be delivered to the pre-designated disposal site for burial. Labels and all necessary signs shall be in accordance with DEQ and OSHA standards.

C. Contractor shall remove decontaminated containers from the site as soon as possible. Notify disposal site in advance of delivery of material to assure immediate burial of containers.

D. If the bags are broken or damaged, or the container is contaminated, the contractor shall clean and decontaminate the entire container for reuse.

E. Contractor shall submit three copies of written proof of disposal at approved disposal site to the environmental consultant prior to completion of the abatement work specified in this section. Use copies of the DEQ Waste Shipment Record ASN-4, completely filled out and signed, and accompanied by tickets and/or receipts from disposal site.

END OF SECTION

Health, Housing & Human Services
CLACKAMAS COUNTY

Richard Swift
Director

April 16, 2020

Housing Authority Board of Commissioners
Clackamas County

Members of the Board:

Approval of Resolution No 1944 Authorizing the Execution, Acknowledgement and Delivery of Closing Documents for the Hillside Manor Rehabilitation Project

Purpose/Outcomes	Approve Resolution No 1944 authorizing the execution and delivery of documents in connection with the financing, rehabilitation, and operation of Hillside Manor Apartments through an Omnibus Resolution
Dollar Amount	Authorizes the full project financing of $27.6MM
Funding Source	4% Low Income Housing Tax Credits (LIHTC), Housing Preservation Funds (OHCS), Perm Loan and HACC Seller Financing
Duration	April 2020 through the closing of the Hillside Manor
Previous Board Action	Resolution #1939, August 2019
Strategic Plan Alignment	1. Sustainable and affordable housing 2. Ensure safe, healthy and secure communities
Contact Person	Jill Smith, Executive Director, Housing Authority
Contract No.	N/A

BACKGROUND:
The Housing Authority of Clackamas County (HACC), a Division of the Health, Housing and Human Services Department requests approval of Resolution 1944, authorizing the execution and delivery of documents by the Authority in connection with the financing, rehabilitation, and operation of Hillside Manor through an Omnibus Resolution. An Omnibus Resolution allows the admittance of all pertinent and relevant financing deal terms and authorities to be captured in one authorizing document.

Hillside Manor is a 100 unit, 9 story residential building, originally constructed in 1970, serving low income households with incomes between 0 - 80% Area Median Income (AMI). The building has been owned and operated by the Housing Authority of Clackamas County (HACC) since original construction. In December of 2017, HACC received approval from the US Department of Housing and Urban Development (HUD) to convert Hillside Manor to a project based Section 8 subsidy under the Rental Assistance Demonstration (RAD) and Section 18 Blend program for Public Housing properties. RAD and Section 18 enables HACC to pursue funding through the Low Income Housing Tax Credit (LIHTC) program to leverage debt and other fund sources and complete renovations on the building. Subsequent to HUD approval, the HACC Development team sought and was awarded LIHTC and Preservation Funding as well as an allocation of Oregon Affordable Housing Tax Credits (OAHTC) from Oregon Housing Community Services (OHCS) to pursue the preservation and robust rehabilitation of Hillside Manor.

Through competitive request for proposal, the HACC Development team sought and selected Tax Credit Equity from US Bank Community Development Corporation (USBCDC) and Construction and Permanent financing from Banner Bank. The project team has arrived at a point with HUD and our other financing partners from Oregon Housing and Community Services (OHCS), US Bank Community Development Corporation (USBCDC), and Banner Bank that we have received our authorizations to move forward with a construction finance closing.

The attached Omnibus Resolution provides the mechanism by which documents necessary for the financial closing of Hillside Manor can be authorized and admitted to the new Limited Partnership. A

similar resolution was previously approved by the board in August of 2019 for the formation of Hillside Manor Limited Partnership.

Some ***key*** components of the Omnibus Resolution are as follows:

- Admits all partners and beneficial financing for the rehabilitation of Hillside Manor to the Limited Partnership.
- Provides Delegation of Authority to the Director of Health, Housing and Human Services, the Executive Director of the Authority and the Director of Housing Development as an Authorized Representative, to act on behalf of the Authority in its own capacity as the Special Limited Partner, and as the sole member of the General Partner to finalize the terms of, execute, acknowledge, and deliver the actions and documents authorized.

Key Components further explained
Omnibus Agreements are standard practice and are used to provide one point of execution for financing documents and authorizations to act on admit regulatory agreements associated with financing documents on behalf of a Limited Partnership. Omnibus Resolutions have most recently been used in conjunction with Easton Ridge, Rosewood Terrace, and previously for the formation of Hillside Manor's Limited Partnership.

Delegation of Authority is also standard practice in complex real estate transactions to grant authority for various members of a development to execute authorized documents in order to initiate closing of the transaction or to authorize construction draws from construction proceeds during rehabilitation of the project.

The Housing Authority has retained Kantor Taylor as outside counsel on the Hillside Manor rehabilitation. Kantor Taylor are the authors of this resolution and have acted as representation for HACC in all matters related to the financial closing and terms of the post-construction ownership and operations of Hillside Manor through the Limited Partnership Agreement (LPA). All documents referenced in the Omnibus or agreements entered into by an Authorized Representative will be reviewed and approved by Kantor Taylor acting as independent third-party counsel for HACC. County Counsel has reviewed this Omnibus Resolution as a courtesy to HACC.

To the extent practical, as may be requested, all documents referenced within the Omnibus Resolution will be provided to the board prior to execution at final closing.

RECOMMENDATION:
Staff recommends that the Board approve Resolution No.1944, Authorizing the Execution and Delivery of Documents in Connection with the Financing, Rehabilitation and Operation of the Hillside Manor Apartments.

Respectfully submitted,

Richard Swift, Director
Health, Housing & Human Services

Attachments:
1. Omnibus Resolution #1944

BEFORE THE BOARD OF COMMISSIONERS

OF THE HOUSING AUTHORITY OF CLACKAMAS COUNTY

In the Matter of Authorizing the Financing and Related Matters, for the Hillside Manor Project	RESOLUTION

NO._____

WHEREAS, the Housing Authority of Clackamas County ("***Authority***") works to provide affordable multifamily housing for persons and families of lower income pursuant to Oregon Revised Statutes ("***ORS***") 456.005 through 456.235; and

WHEREAS, ORS 456.120(18) provides that a housing authority may enter in a partnership agreement with or loan money to an individual, partnership, Housing Authority or other association to finance, plan, undertake, construct, acquire or operate a housing project; and

WHEREAS, ORS 456.065 defines "housing project" to include, among other things, "any work or undertaking ...to provide decent, safe, sanitary urban or rural housings for persons or families of lower income"; and

WHEREAS, ORS 456.055 and 456.175 provide that a housing authority may issue bonds, notes, interim certificates, debentures or other obligations for any of its corporate purposes; and

WHEREAS, the Authority has determined that it is consistent with its purpose to rehabilitate a 100-unit multifamily rental project known as Hillside Manor Apartments located at 2889 SE Hillside Ct., Milwaukie, OR (the "***Project***"); and

WHEREAS, the Project is currently owned by the Authority; and

WHEREAS, for the purpose of carrying out the Project, the Authority has formed and is the sole member and manager of Hillside Manor GP LLC, an Oregon limited liability company (the "***General Partner***"), which is a general partner of Hillside Manor Limited Partnership, an Oregon limited partnership (the "***Partnership***"); and

WHEREAS, the Authority is the initial limited partner of the Partnership; and

WHEREAS, the Authority has determined it to be in the best interests of the Authority and the Project to sell Hillside Manor Apartments and all related improvements, easements, rights, and privileges, belonging or appurtenant to such (collectively, the "***Improvements***") to the Partnership; and

WHEREAS, the Authority has determined it to be in the best interests of the Authority and the Project to hold a note from the Partnership for a portion of the approximately **$6,050,000** sales price (as such amount may change based on appraisal) of the Improvements in the amount of approximately **$5,747,500** (the "***Seller Loan***") (as such amount may change based on underwriting); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority and the Project to authorize the lease of the land beneath the Improvements (the "***Land***") to the Partnership pursuant to a ground lease (the "***Ground Lease***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity and as sole member of the General Partner), the Partnership, and the Project to obtain a low-income housing tax credit ("***LIHTC***") investment in the Partnership of approximately **$8,159,418** (which amount may change based on underwriting) (the "***LP Investment***") from U.S. Bancorp Community Development Corporation, a Minnesota corporation, and/or its successors or assigns ("***USBCDC***") and to admit USBCDC as limited partner of the Partnership; and

WHEREAS, as part of the LP Investment, USBCDC requires that the current Agreement of Limited Partnership of the Partnership be amended and restated in its entirety to reflect the terms of the LP Investment (the "***Amended Partnership Agreement***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to take all actions reasonably necessary to facilitate the LP Investment in the Partnership by USBCDC by entering into all reasonably necessary agreements with USBCDC and the Partnership (collectively the "***Syndication Documents***") and by taking such further actions as are reasonably necessary as to facilitate the LP Investment in the Partnership by USBCDC; and

WHEREAS, the Authority will be required to enter into a guaranty agreement in favor of USBCDC guarantying payment and performance of the obligations and duties of the Authority under the Syndication Documents; and

WHEREAS, upon the admission of USBCDC as a limited partner of the Partnership, the Authority desires to reduce and retain its limited partnership interest in the Partnership as a special limited partner (the "***Special Limited Partner***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the

Partnership, and the Project, to accept an award of LIHTC from the State of Oregon, acting by and through its Housing and Community Services Department ("***OHCS***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to enter into a 4% Low-Income Housing Tax Credit Reservation and Extended Use Agreement, 4% Low-Income Housing Tax Credit Declaration of Land Use Restrictive Covenants, 4% Tax Credit Allocation Indemnity and Hold Harmless Agreement, and such other documentation as may be reasonably required in connection with obtaining the allocation of LIHTC (collectively, the "***Tax Credit Documents***"); and

WHEREAS, the State of Oregon, acting through its Treasurer and OHCS (the "***Bond Issuer***"), has approved or will approve the issuance of tax-exempt multi-family housing revenue bonds in the approximate amount of **$15,000,000** (the "***Bond Issuance***" and the "***Bonds***"). The Bonds will be privately placed with Banner Bank (the "***Bank***") to provide construction financing for the Project (the "***Construction Loan***"), with a portion of the Construction Loan to convert to a permanent loan from the Bank to provide a portion of the permanent financing for the Project in the approximate amount of **$6,720,000**, as such amount may change based on underwriting, (the "***Permanent Loan***"); and

WHEREAS, the Construction Loan and Permanent Loan will be evidenced by those documents listed on **Exhibit A** attached hereto, and such other documentation as may be reasonably required in connection with the making of the Construction Loan and the Permanent Loan to Partnership (collectively, the "***Loan Documents***"); and

WHEREAS, the Authority deems it to be in the best interests of the Authority to enter into any environmental indemnity, guaranty agreement and completion agreement which may be required by Bank under the Loan Documents; and

WHEREAS, in connection with the Bond Issuance, the Partnership, General Partner, and the Authority will be required to execute to execute the documents listed on **Exhibit A**, and such other documents as may be required by the issuer and/or bond counsel (together, the "***Bond Documents***"); and

WHEREAS, the Permanent Loan will be partially subsidized by Oregon Affordable Housing Tax Credits ("***OAHTC***") and the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner) the Partnership, and the Project to enter in to an Oregon Affordable Housing Tax Credit Program Declaration of Land Use Restrictive Covenants with the State of Oregon, and any other documents as are reasonably required to obtain the award of OAHTC (the "***OAHTC Documents***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to cause the Authority to contribute capital to the Project in the approximate amount of **$3,000,000,** as such amount may change based on underwriting, of

Authority funds (the "***Authority Funds***"), either in the form of a loan or a capital contribution to the Partnership, or a combination of the two, to be used for Project purposes and, in the case of a loan, for a term and at an interest rate as shall be determined by any Authorized Representative (such determination to be conclusively demonstrated by the signature of any Authorized Representative on such document); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to cause the Authority to enter into such agreements as are reasonably necessary to obtain a grant in the approximate amount of **$3,428,811** of state Lottery Backed Bonds for Preservation Program funds (the "***Preservation Funds***") from OHCS and, thereafter, to lend the proceeds of such grant to the Partnership for a term and at an interest rate as shall be determined by an Authorized Representative (such determination to be conclusively demonstrated by the signature of any Authorized Representative on such document); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to cause the Authority to convert 70 public housing units in the Project to Project-Based Section 8 units pursuant to the United States Department of Housing and Urban Development's ("***HUD***") Rental Assistance Demonstration ("***RAD***") program (the "***RAD Conversion***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to cause the Authority to convert 30 public housing units in the Project to Project-Based Section 8 units through HUD's Section 18 conversion program (the "***Section 18 Conversion***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to engage the Authority as developer of the Project and to defer a portion of its developer fee for the benefit of the Project;

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project to authorize the execution and delivery of certain agreements for architectural, construction, property management, and technical related services related to the Project (the "***Project Documents***"); and

WHEREAS, the Authority has determined it to be in the best interests of the Authority (in its individual capacity, as sole member of the General Partner, and as Special Limited Partner), the Partnership, and the Project for the Authority to assign to the Partnership certain Project Documents the Authority entered into prior to the admission of USBCDC as the limited partner.

NOW, THEREFORE, THE AUTHORITY IN ITS OWN CAPACITY, ITS SEPARATE CAPACITY AS THE SPECIAL LIMITED PARTNER, AND AS THE SOLE MEMBER AND MANAGER OF THE GENERAL PARTNER OF THE PARTNERSHIP, ADOPTS THE FOLLOWING RESOLUTIONS:

Section 1. Approve Amended Partnership Agreement, Admission of USBCDC; Execution of Syndication Documents.

BE IT RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, a letter of intent relating to an anticipated Amended Partnership Agreement of the Partnership among the Authority (as Special Limited Partner), the General Partner, and USBCDC, in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

BE IT FURTHER RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Syndication Documents listed on the attached **Exhibit A** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the closing of the LP Investment by USBCDC, all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 2. Approve Sale of the Improvements to the Partnership.

BE IT RESOLVED, that the Authority is authorized to negotiate, execute, and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, as the case may be, the documents as reasonably may be required in connection with the sale of the Improvements to the Partnership all in the form and for a price approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 3. Approve the Seller Loan.

BE IT RESOLVED, that in connection with the sale of the Improvements, the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Seller Loan Documents listed on the attached **Exhibit A** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the Seller Loan all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 4. Approve the Ground Lease.

BE IT RESOLVED, that any Authorized Representative is hereby authorized to execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Ground Lease for the Land with the Partnership as lessee and the Authority as landlord with such terms and conditions as any single Authorized Representative shall approve (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 5. Approve Bond Documents.

BE IT RESOLVED that the Bonds are approved and the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Bond Documents listed on the attached **Exhibit A** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the issuance of the bonds all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 6. Approve Construction Loan from Bank.

BE IT RESOLVED, that the Construction Loan is approved and the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Construction Loan Documents listed on the attached **Exhibit A** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the closing of the Construction Loan all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 7. Approve Permanent Loan from Bank.

BE IT RESOLVED, that the Permanent Loan is approved and the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Permanent Loan Documents listed on the attached **Exhibit A** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the closing of the Permanent Loan all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 8. Approve OAHTC Documents.

BE IT RESOLVED that the OAHTCs are approved and the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the OAHTC Documents and such

other documents as reasonably may be required in connection with the OAHTCs all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 9. Approve Tax Credit Documents.

BE IT RESOLVED that the LIHTCs are approved and the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Tax Credit Documents listed on the attached **Exhibit A** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the issuance of the bonds all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 10. Approve Contribution of the Authority Funds to the Partnership.

BE IT RESOLVED, that the Authority Funds are approved and the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, such documents as are required to evidence the contribution of the Authority Funds, either as a loan or a capital contribution, or a combination of both, to the Partnership, all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any Authorized Representative on such documents).

Section 11. Approve Receipt of the Preservation Funds by the Authority.

BE IT RESOLVED, that the Preservation Funds are approved and the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, such documents as are required to evidence and obtain the grant of the Preservation Funds all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 12. Approve Loan of the Preservation Funds to the Partnership.

BE IT RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the Sponsor Loan Documents listed on the attached **Exhibit A** (whether bearing the name listed or names to similar effect), and such other documents as required to evidence and secure a loan of the Preservation Funds to the Partnership all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 13. Approve the RAD Conversion.

BE IT RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the documents necessary to close on the RAD Conversion including but not limited to the execution and delivery of those documents identified on **Exhibit A** (whether bearing the name listed or names to similar effect) all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such document).

Section 14. Approve the Section 18 Conversion.

BE IT RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the documents necessary to close on the Section 18 Conversion including but not limited to the execution and delivery of those documents identified on **Exhibit A** (whether bearing the name listed or names to similar effect) all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such document).

Section 15. Approve the Authority as Developer.

BE IT RESOLVED, that the Authority is authorized to serve as developer of the Project and to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, the documents necessary to engage the Authority as developer and to defer a portion of the developer fee.

Section 16. Approve Project Documents.

BE IT RESOLVED that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority, the General Partner, the Special Limited Partner, and/or the Partnership, as the case may be, all contracts and other documents respecting the design, construction, property management, and technical assistance for the Project all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such document).

Section 17. Approve Assignment of Project Documents.

BE IT RESOLVED, that the Authority is authorized to assign to the Partnership and the Partnership is authorized to assume the Project Documents entered into by the Authority before USBCDC was admitted as limited partner, all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such document).

Section 18. Delegation.

BE IT RESOLVED, that the Executive Director of the Authority, the Director of Health, Housing and Human Services, and the Director of Housing Development is each an Authorized Representative, as that term is used in these Resolutions, and each may individually, on behalf of the Authority, in its own capacity, as the Special Limited Partner, and as the sole member of the General Partner, and without further action by the Board, finalize the terms of, execute, acknowledge, and deliver the actions and documents authorized herein.

Section 19. General Resolutions Authorizing and Ratifying Other Actions.

BE IT RESOLVED, that any Authorized Representative is authorized to negotiate, execute and deliver on behalf of the Authority (whether in its own capacity, its capacity as Special Limited Partner, or as sole member of the General Partner) or the Partnership, as the case may be, such other agreements, certificates, and documents, and to take or authorize to be taken all such other actions any Authorized Representative shall deem necessary or desirable to carry out the transactions contemplated by the foregoing resolutions (such determination to be conclusively demonstrated by the signature of any single Authorized Representative on such document); and

BE IT FURTHER RESOLVED, that to the extent any action, agreement, document or certification has heretofore been taken, executed, delivered or performed by an Authorized Representative named in these Resolutions on behalf of the Authority (whether in its own capacity, its capacity as Special Limited Partner, or as sole member of the General Partner) or the Partnership and in furtherance of the Project, the same is hereby ratified and affirmed.

DATED THIS ____ DAY OF MARCH, 2020

BOARD OF COMMISSIONERS FOR THE HOUSING AUTHORITY OF CLACKAMAS COUNTY

_____
Chair

_____
Recording Secretary

APPROVED AS TO FORM

_____
COUNSEL FOR HOUSING AUTHORITY
OF CLACKAMAS COUNTY, OREGON

EXHIBIT A

Syndication Documents

1. Amended and Restated Agreement of Limited Partnership of Hillside Manor Limited Partnership
2. Guaranty Agreement
3. Joint Marketing Agreement
4. Partnership Management Agreement
5. Development Services Agreement
6. Such other documents as required in connection with the closing of the investment by USBCDC

Tax Credit Documents

1. 4% Reservation and Extended Use Agreement
2. 4% Hold Harmless Agreement
3. Such other documents as required in connection with the closing of the tax credits

Bond Documents

1. Loan Agreement
2. Regulatory Agreement
3. Operating Agreement and Declaration of Restrictive Covenants and Equitable Servitudes
4. Tax Certificate and Agreement
5. Priority and Subordination Agreement
6. Such other documents as are required in connection with the issuance of the Bonds

Construction Loan Documents and Permanent Loan Documents

1. Assignment of Architect Contract and Plans
2. Assignment of Construction Contracts and Permits
3. Assignment of Rights Under Housing Assistance Payments Contract
4. Assignment of Rights Under Development Agreement
5. Assignment of Rights Under Management Agreement
6. Commercial Guaranty
7. Corporate Certification to Guaranty
8. Hazardous Waste Warranty and Indemnification Agreement
9. Line of Credit Leasehold Deed of Trust, Assignment of Leases & Rents, Security Agreement and Fixture Filing
10. Promissory Note (Tax Exempt)
11. Renovation and Term Loan Agreement
12. Replacement Reserve and Security Agreement
13. Certification to Borrow and Grant Security
14. Consent to Assignment of HAP Contract
15. Landlord's Consent and Subordination Agreement
16. Promissory Note (Taxable)
17. SNDA (New Singular Wireless PCS, LLC)
18. UCC Financing Statement

19. Such other documents as required in connection with the closing of the Construction Loan and Permanent Loan

Seller Loan Documents

1. Promissory Note
2. Trust Deed
3. Such other documents as required in connection with the closing of the Seller Loan

Sponsor Loan Documents

1. Promissory Note
2. Trust Deed
3. Such other documents as required in connection with the closing of the Sponsor Loan

RAD Conversion Documents

1. Housing Assistance Payment Payments (HAP) Contract and any applicable Riders
2. RAD Use Agreement
3. RAD Conversion Commitment
4. Certifications and Assurances
5. Releases of Declarations of Trust
6. Such other documents as are required in connection with the RAD Conversion

Section 18 Conversion Documents

1. Housing Assistance Payment Payments (HAP) Contract and any applicable Riders
2. Such other documents as are required in connection with the Section 18 Conversion

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

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

April 16, 2020

Board of County Commissioners
Clackamas County

Members of the Board:

Resolution to Amend the Transportation System Development Charges Methodology Report, Modifying the TSDC Rate Schedule to Establish New Rates for Single Family Residential Homes and Accessory Dwelling Units

Purpose/Outcome	Amendments to the Transportation System Development Charges Methodology Report and TSDC Rate Schedule by Resolution.
Dollar Amount and Fiscal Impact	Our estimated MAXIMUM annual impact is $25,000, which is minimal in context to the entire TSDC Revenue projections which top $210 million over the 20-year life of the plan.
Funding Source	Clackamas Countywide TSDC Funds (Fund 223)
Duration	New TSDC methodology and rates will take effect on development applications received for review in Clackamas County beginning July 1, 2020.
Previous Board Action/Review	Board Policy Session on this topic on 11/5/2019, titled "Tiered Residential Transportation System Development Charge (TSDC) Program Proposal"
Strategic Plan Alignment	The modification to existing rates that will result from aligning the TSDC rate for Single Family Detached homes with the traffic impact of home size fluctuations, will increase trust with citizens paying this fee for new development. [Building public trust through good government.] Ensuring our rates are aligned with resident behavior will ensure we are able to invest in capital facilities to add capacity to the county road system as new development occurs. [Build public trust through good government.] Charging new development the correct amount to cover added infrastructure needs, ensures we are collecting the right amount of money to build the infrastructure improvements to support our growing region. [Building strong infrastructure.]
Counsel Review	Reviewed and approved by County Counsel on April 7, 2020. (NB)
Procurement Review	1. Was the item processed through Procurement: Yes 2. The contract to perform the Residential TSDC Review was processed through procurement; this resolution adopts the resulting plan amendments and does not require procurement review.
Contact Person	Diedre Landon, DTD Administrative Services Manager @ 503-742-4411

BACKGROUND:

Local governments rely on System Development Charges (SDCs) to collect money for capital improvements on a variety of infrastructure systems, such as roads, water, sewer, storm drains and schools. Transportation System Development Charges (TSDCs) are one-time fees assessed to new or expanded developments to help cover the cost of adding to the capacity of transportation facilities for motorists, bicyclists and pedestrians to accommodate new trips added by the development. TSDC fees are based on the number of vehicle trips a particular land use generates, and are paid by the developer when a building permit is issued.

In January 2018, the County adopted a new Transportation System Development Charge (TSDC) plan. At that time, many regional discussions were focused on tiered residential SDC rates, and the Board of County Commissioners was interested in the concept. The original work group did not have the necessary data to decide whether actual behaviors and travel data would support a tiered residential rate. So when the new TSDC plan was adopted in 2018, the county continued having one rate per detached single-family home dwelling unit, regardless of the size of the home. However, staff was asked to revisit the concept of a tiered residential rate, and to determine whether there is a link between home size and number of transportation trips in Clackamas County.

Tiered Residential Rate Structure

In November 2018, after hiring a consultant to help analyze the data, the County brought together a group of stakeholders to consider a tiered residential TSDC rate. The group was made up of representatives from the development community, a member of the Home Builders Association (HBA), a county resident interested in developing an Accessory Dwelling Unit (ADU) on their land and County staff.

The group met three times between October 2018 and July 2019 to review the analysis and develop a recommendation, as reflected in the amendments to the Transportation System Development Charges Methodology Report, which would modify the TSDC rate schedule to establish new rates for Single Family Homes and Accessory Dwelling Units (see Attachments A, C and D).

- The data supports a tiered residential TSDC rate structure for detached single-family homes, and the work group recommends a three-tier rate structure for these units (see Attachment B).
- There is little data available for smaller homes, such as accessory dwelling units. However, the group considered the smaller home size compared existing residential rates, ultimately recommending a two-tiered rate structure for accessory dwelling units using the ITE trip rates for Condo/Townhomes as a baseline (see Attachment B).
- The group also discussed concerns with implementing the new program, like the implication of additions to single-family homes and recommends that the County exempt additions or detached units that are 199 square feet or smaller.

After extensive deliberation, the work group recommends that the County continue assessing TSDCs for multifamily residential units, without additional consideration of the size of the unit. This is based on the fact that the County ordinance has a number of potential discounts available to multifamily development projects.

Revenue Neutrality

The final step in the analysis was to explore whether the recommended TSDCs would be revenue neutral with respect to the current TSDC structure. Based on the distribution of permits since 2010, the 3-tier approach is not expected to generate revenue that is materially different than the current rate. We would expect to collect about 98% of our "detached single family home" assessments, which is one of a number of categories we assess against. Revenue projections from this category comprise approximately 16% of the total expected TSDC revenue over twenty years. Our estimated maximum annual impact is $25,000, which is minimal in context to the entire TSDC Revenue projects, which top $210 million over the life of the plan.

Any "balancing" to ensure no loss of revenue would require an increase in other residential rates. In the context of the County's desire to support housing, the lost revenue does not seem significant enough to warrant an increase in these other housing categories to support the tiered Residential TSDC Rate at this time. However, there will be a formal plan update in 2021, which will allow us to reassess this policy decision as we review construction costs, project lists and the traffic impact distribution to bring all categories current.

Public Input

In accordance with state law, we published notice of our methodology update 90 days prior to the public hearing for adoption, which will take place on May 7, 2020. Notice was published online, through social media and emails were sent to interested parties.

RECOMMENDATION:

Staff recommends the Board of County Commissioners ask staff to return on May 7, 2020, for approval of the attached resolution amending the Transportation System Development Charges Methodology Report, modifying the TSDC rate schedule to establish new rates for Single Family Homes and Accessory Dwelling Units (see Attachment A) with an effective date of July 1, 2020.

Respectfully submitted,

Diedre Landon

Diedre Landon
Administrative Services Manager, Snr.

Attachments

Attachment A: DRAFT Resolution to amend the Transportation System Development Charges Methodology Report, Modifying the TSDC Rate Schedule to establish new rates for Single Family Residential Homes and Accessory Dwelling Units.
Attachment B: Infographic: Tiered Transportation System Development Charge (TSDC) Rates – Proposed | Detached Single-Family Homes & Accessory Dwelling Units
Attachment C: Tiered Residential Transportation System Development Charge (TSDC) Program: Work Group Decision Overview
Attachment D: Portland Metro Home Builders Association Testimony

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

A Resolution to Amend the Transportation System Development Charges Methodology Report, Modifying the TSDC Rate Schedule to Establish New Rates for Single Family Residential Homes and Accessory Dwelling Units

Resolution No. _____

Whereas, on January 28, 1993, the Board of County Commissioners established a Transportation System Development Charge (TSDC) program in Clackamas County (County Code, Chapter 11.03), recognizing that development should contribute its fair share to the cost of improvements and additions to transportation facilities necessary to accommodate the capacity needs created by growth; and

Whereas, TSDC revenue is allocated to projects annually through the County's budgeting process; and

Whereas, the County prepared a February 2020 Transportation System Development Charge Methodology Report, attached to this Resolution as Exhibit A and incorporated herein by this reference, as the guiding document for formulating a transportation system development charge as authorized by state law; and

Whereas, Oregon's System Development Act (Oregon Revised Statutes 223.297 - 223.314) requires that system development charges be based on a methodology that demonstrates consideration of capital improvement costs identified in an adopted list of projects that are needed to increase capacity to serve the demands of future users (Exhibit A, Appendix A – TSDC Capital Project List); and

Whereas, using the TSDC Capital Project List, the methodology calculates the TSDC Rate Schedule (Exhibit A, Appendix B – TSDC Rate Schedule); and

Whereas, under the existing TSDC rate schedule, there is a single category for single family residential rates, regardless of traffic impact due to fluctuations in home size; and

Whereas, under the proposed TSDC fee schedule, there are three categories identified for single family homes to account for modified traffic impacts of larger and smaller homes; and

Whereas, under the existing TSDC rate schedule, there is no category identified for Accessory Dwelling Units (ADU) and historically these have been assigned the Apartment/Multi-Family Dwelling rates; and

Whereas, under the proposed TSDC fee schedule, there are two Accessory Dwelling Unit categories, using the Condo/Townhome ITE rate as a baseline, to account for modified traffic impacts of larger and smaller ADU units; and

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

A Resolution to Amend the Transportation System Development Charges Methodology Report, Modifying the TSDC Rate Schedule to Establish New Rates for Single Family Residential Homes and Accessory Dwelling Units

Resolution No. _____

Whereas, pursuant to ORS 223.304, the methodology was available for public inspection for more than 60 days prior to the first public hearing on the matter, and written notice of the proposed transportation SDC methodology was sent to people who requested such notice 90 days prior to the first public hearing; and

Whereas, the Board of County Commissioners scheduled, noticed and held a public hearing on the new transportation SDC rates and supporting documentation and accepted public testimony on the proposed new transportation SDC rate categories during a public hearing at its regular meeting on April 16, 2020, and again on May 7, 2020; and

Whereas, the new rates will take effect on July 1, 2020 to coincide with regular annual rate adjustments; and

Whereas, no changes are proposed to County Code Chapter 11.03, which will maintain all other aspects of the County's TSDC program such as those provisions related to credits and refunds.

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

1. To modify the Transportation System Development Charges Methodology Report, effective January 1, 2018, attached to this Resolution as Exhibit A, modifying the rates for single family homes and establishing new rate categories for Accessory Dwelling Units, effective July 1, 2020.

DATED this _____ day of May, 2020.

BOARD OF COUNTY COMMISSIONERS

_____
Chair

_____
Recording Secretary

Methodology Report

Transportation System Development Charges

Prepared For
Clackamas County

September 7, 2017
Effective January 1, 2018
With proposed modifications February 13, 2020

GALARDI ROTHSTEIN GROUP

In Association with DKS Associates and Randy Young

Executive Summary

Background

Oregon Revised Statutes 223.297-223.314 authorize local governments to charge System Development Charge (SDCs) for transportation and other capital improvements. Local governments rely on System Development Charges (SDCs) to collect money for capital improvements on a variety of infrastructure systems, such as roads, water, sewer, storm drains and schools.

Transportation System Development Charges (TSDCs) are one-time fees assessed to new or expanded developments to help cover the cost of adding to the capacity of transportation facilities (for motorists, bicyclists and pedestrians) to accommodate new trips added by the development. The TSDC fees are based on the number of vehicle trips a particular land use generates, and are paid by the developer when a building permit is issued.

Clackamas County (the County) embarked on an effort to update its transportation system development charges (TSDCs) in 2016, in conjunction with the City of Happy Valley (the City). The City and County have a Joint Area TSDC, adopted through an intergovernmental agreement (IGA) in 2007.

The purpose of the Transportation SDC Update Project (the Project) was to review the current methodology in the context of current industry practices, statutory requirements and infrastructure funding needs. In addition to the methodology review, a major component of the Project was to update the transportation system development charge capital project lists to reflect recently completed Transportation System Plans (TSP), and to review service area boundaries.

Over the course of the Project, the City and County agreed to terminate the existing Joint Area TSDC Program, and instead pursue development of TSDCs and TSDC Capital Project Lists specific to each entity. This report presents the methodology, project list, and updated TSDCs for the County.

Stakeholder Involvement and Outreach

A Work Group made up of stakeholders and technical staff was convened to provide input during the TSDC methodology update. Members represented a wide range of interests and included residential and commercial real estate developers, residential and commercial builders, engineering firms and business associations. County and City staff participated in Working Group meetings to provide technical expertise and information.

Online Open Houses

County and City staff invited the public to participate in online open houses through emails, press releases, website announcements, newsletter articles, and social media outreach. The online open houses included background information about the TSDC update, a geographic interactive map of potential projects and survey questions. The public was invited to learn about the TSDC update and provide their input on the project list, the rates and the traffic impact being measured. In total, about 230 people visited the online open houses, and 45 people submitted completed comment forms.

Feedback collected through work group meetings and the online open houses helped formulate the Project recommendations.

Summary of Methodology

The transportation SDC is based on a system-wide cost per trip, where the costs associated with meeting future growth needs are divided by the projected system-wide growth in trips. The updated TSDC methodology is structured as an improvement fee only, as provided under Oregon law. As such, the cost per trip is calculated by dividing the growth-related capacity costs from the TSDC Capital Project List by the 471,812 additional daily trips (from the regional traffic model).

In addition to the fee structure, local governments have flexibility in selecting among other methodological approaches, in order to meet local policy objectives. Components considered during the Project include the growth share bases, measuring the traffic impact, adjustments to traffic impact and the land use categories used to develop the rate table.

TSDC Capital Project List

Unlike the current methodology, which only considers the added trips by vehicles on the County system; the updated TSDC methodology considers the added trips by all modes of travel (auto, pedestrian, and bicycle). Rather than focusing on building large capacity projects, the new project list also incorporates solutions that provide more efficient travel on existing roads.

The Draft TSDC Capital Project List was developed from two sources:

- Transportation System Plan (TSP); and
- Clackamas Regional Center (CRC) Project List

Combined, these two project lists included over 438 projects with a total cost in excess of $2.82 billion. The work group selected criteria that focuses on growth created by new development for identifying projects from these two plans to remain on the list and become eligible for TSDC funding.

- Increase traffic connections to daily needs and services.
- Reduce congestion at intersections.
- Located in or near a current or future employment area.
- Improve safety on roads.
- Provide the greatest benefit to the entire community by keeping projects on roads with significant amounts of traffic, such as arterials and collectors.
- Projects planned for construction in the next 10-years.

The resulting prioritization produced a Draft TSDC Capital Project List containing 76 projects with total project costs of $476 million. Of the total project costs, $210 million is attributable to growth, and therefore eligible for SDC Funding.

The process used to develop the TSDC Capital Project List is detailed in Section 2-1.

The full project list can be found in Appendix A (Table A-1).

Proposed TSDC Schedule

TSDC rates differ by land use based on the number of trips a new or expanded development is estimated to add to the transportation system. For example, the TSDC fee for an average single-family home is lower than the fee for a large grocery store because it generates fewer trips. The proposed SDCs for single-family residential development are based on one of three dwelling size categories. Additionally, two categories of accessory dwelling units (ADUs) are also proposed.

Currently, Clackamas County has a long list of rates, one for each specific type of nonresidential land use. The new plan focuses on streamlining and simplifying the program for our customers by considering a short consolidated nonresidential rate list in place of our current long rate list.

The proposed rates consolidate similar uses and reduce the number of rates making it easier for developers and the public to identify the correct rate and reducing the likelihood that commercial tenant improvements in an existing structure will trigger a TSDC fee.

The process used to develop the TSDC Rate Schedule is detailed in Section 3-1.

The updated TSDC rate schedule is shown in Appendix B.

Report Contents

Data Rounding

The data presented in tables of this report are exported from computer spreadsheets. In some tables, there will be very small variations from the results that would be obtained using a calculator. These variations are not material, and result from the fact that the spreadsheet was allowed to calculate figures to more decimal places than the tables shown in this report.

SECTION 1

Introduction

Background

Oregon Revised Statutes 223.297-223.314 authorize local governments to assess System Development Charge (SDCs) for transportation and other capital improvements. In addition to specifying the infrastructure systems for which SDCs may be assessed, the SDC legislation provides guidelines on the calculation and modification of SDCs, accounting requirements to track SDC revenues, and the adoption of administrative review procedures.

Clackamas County (the County) last updated in transportation system development charges (TSDCs) in 2007, in conjunction with the City of Happy Valley (the City).

Project Objectives

The purpose of the Transportation SDC Update Project (the Project) was to review the current methodology in the context of current industry practices and statutory requirements and infrastructure funding needs. In addition to the methodology review, a major component of the Project was to update the TSDC capital project list to reflect projects and priorities from the updated Transportation System Plan (TSP) adopted in 2013.

Specific Project objectives included:

- Development of TSDCs that balance the need to fund transportation improvements while taking into account the impact on overall development costs.
- Identify ways to simplify the TSDC rate structure, making it easier for developers and community members to estimate fees.
- Involve key stakeholders in the process to give feedback on project list selection criteria and the updated methodology and ordinance.
- Review the current service area boundaries.

With respect to the latter issue of service area boundaries, as part of the Project, the City and County agreed to terminate the existing Joint Area TSDC Program, and instead pursue development of TSDCs and capital project lists specific to each entity. A new IGA was authorized in August 2017 that outlined the terms of separation for the program. The City and County worked collaboratively on the review and development of the new TSDC methodologies and ordinances that will serve as the framework for the individual TSDC programs going forward. This report presents the methodology, project list, and updated TSDCs for the County. While the general framework is consistent between the two entities, the individual TSDC programs also reflect policies and objectives specific to each.

Stakeholder Involvement

A Working Group made up of stakeholders and technical staff was convened to provide input to help shape the TSDC methodology update and rates. The group met eight times between December 2015 and August 2017. Members reviewed and provided input on the following topics:

- TSDC project list and selection criteria
- Method used to calculate growth share of projects
- TSDC rate calculation and schedule
- Ordinance for administration of TSDCs, including a review of the language governing

Members represented a wide range of interests and included residential and commercial real estate developers, residential and commercial builders, engineering and planning firms, and business associations. County and City staff participated in Working Group meetings to provide technical expertise and information. Stakeholder members included representatives from the following groups:

- Home Builders Association
- Gramor Development
- Perkins Coie
- AKS Engineering
- Doug Bean & Associates
- Holt Homes
- North Clackamas Chamber of Commerce

Online Open Houses

The public was invited to learn about the TSDC update and provide their comments on specific elements of the methodology and project list. Comments were primarily gathered through two online open houses for the County and the City between April 18 and May 19, 2017. The online open houses included background information about the TSDC update, a geographic interactive map of potential projects, and survey questions. Participants were asked specific questions about the criteria used to select projects for the TSDC project list; approaches to simplifying the rates used to calculate TSDC fees; and options for calculating traffic impacts of new developments.

County and City staff invited the public to participate in the online open houses through more than 1,600 direct emails to interested parties, press releases, website announcements, newsletter articles and social media (Facebook and Twitter) outreach.

In total, about 230 people visited the online open houses, and 45 people submitted completed comment forms. This feedback helped formulate the Project recommendations.

SECTION 2

TSDC Capital Project List Development

Introduction

The first step in updating the countywide TSDC was to identify the list of capital projects eligible to receive TSDC revenue, because that sets the foundation for calculating the rates for different kinds of development.

The Draft TSDC Capital Project List was developed from two sources: the Transportation System Plan (TSP) and the Clackamas Regional Center (CRC) Project List. Combined, the two project lists included over 438 projects with a total cost in excess of $2.82 billion.

Project Prioritization

TSDC funds can only be used to build projects that accommodate additional traffic generated by new development. The current County TSP built on the foundation of existing county assets with a fiscally responsible approach that protects and improves the existing transportation system and implements a cost-effective system to meet future needs. Rather than focusing on building large capacity projects to improve our existing network, the plan incorporates solutions that provide more efficient travel on existing roads. As a result, there was a need to identify the capacity increasing projects that were eligible for TSDC funding.

The work group chose the following criteria that focuses on growth created by new development for selecting projects from the Transportation System Plan (TSP) and other locally adopted plans that will remain on the list and become eligible for TSDC funding.

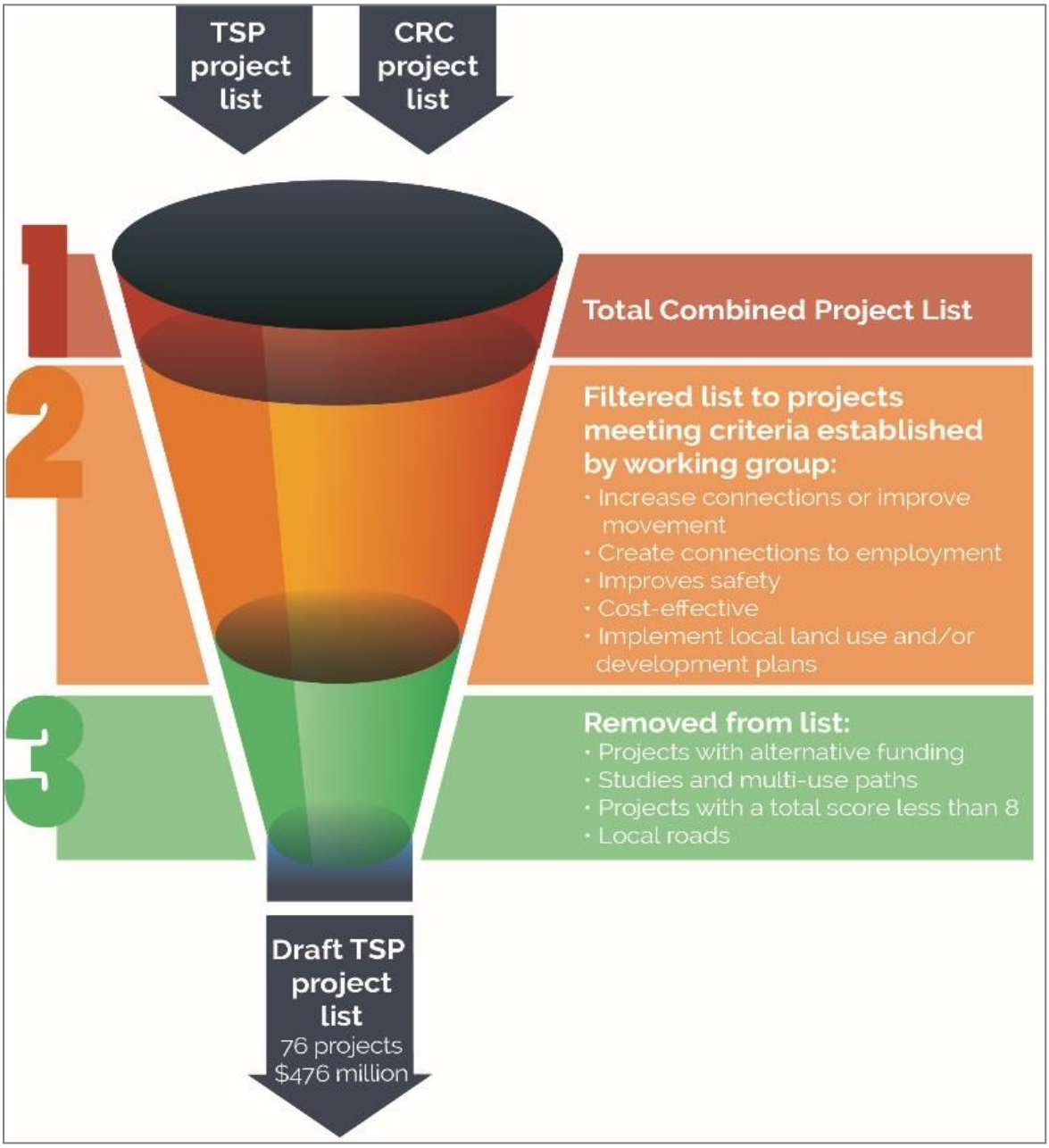
- Increase traffic connections to daily needs and services.
- Reduce congestion at intersections.
- Located in or near a current or future employment area.
- Improve safety on roads.
- Provide the greatest benefit to the entire community; on roads with significant amounts of traffic, such as arterials and collectors.

Only those projects on the CRC Project list with capacity enhancing elements were kept; however, in order to minimize potential increases to the final TSDC rates, the work group needed to reduce the number of projects from the 20-year TSP that would become eligible for TSDC funding. During development of the TSP each project was scored for their achievement of six goals on a scale of (-1) to 2. Using the original scoring, which was vetted during the public outreach for the TSP, work group members chose to keep TSP projects scoring higher than 0 on the following goals for the draft TSDC Capital Project list:

- Goal 2: Local Businesses and Jobs
- Goal 3: Livable and Local
- Goal 4: Safety and Health

In addition to the above prioritization, the following were removed from the draft TSDC Capital Project List:

- Projects with alternative funding
- Studies and multi-use paths
- Projects with less than a total score of 8 (The combined score from all six TSP goals)
- Local Roads



The result of these prioritization efforts is a draft TSDC Capital Project List containing 76 projects with total project costs of $476 million. Of the total project costs, $210 million of the total estimated construction cost is eligible for TSDC Funding.

Project Cost Estimation

The project costs identified in the TSDC Capital Project List are based on the cost estimates developed as part of the TSP or CRC studies. Appendix C –County Transportation System Plan Update Cost Estimate Assumptions documents the assumptions made in preparing cost estimates for the projects on the Master List for the Clackamas County Transportation System Plan (TSP) Update.

All TSP and CRC project costs have been updated to reflect estimated inflation since the original project costs were developed. The total estimated cost of the prioritized list is $476 million, as shown in Table 2-1 below.

TSDC Capital Project List

The prioritization outlined above produced a Draft TSDC Capital Project List containing 76 projects with total project costs of $476 million. Of the total project costs, $210 million is attributable to growth, and therefore eligible for SDC Funding. The full project list can be found in Appendix A (Table A-1).

A summary of the TSDC improvement project costs by project type is provided in Table 2-1.

Table 2-1
Summary of TSDC Capital Project List Costs

	Mode				
Location	Auto	Ped	Bike	**Total**	**TSDC-Eligible**
Urban	$32,453,596	$132,363,431	$61,892,355	$226,709,382	$105,388,058
Rural	248,502,038	1,060,062	-	249,562,100	104,920,618
Total	**$280,955,634**	**$133,423,493**	**$61,892,355**	**$476,271,482**	**$210,308,676**
Percent	*59%*	*28%*	*13%*	*100%*	*44%*

The full project list can be found in Appendix A (Table A-1).

SECTION 3

TSDC Methodology

Introduction

The transportation SDC is based on a system-wide cost per trip, where the costs associated with meeting future growth needs are divided by the projected system-wide growth in trips. The TSDC for a particular development is then determined by multiplying the cost per trip by the number of trips associated with the development. These calculations are outlined below.

System-Wide Cost per Trip

The updated TSDC methodology is structured as an improvement fee, as provided under Oregon law. An improvement fee is designed to recover costs of *planned future* capital improvements needed to add system capacity for future users. As such, the cost per trip is calculated by dividing the growth-related capacity costs from the TSDC Capital Project List by the future growth in trips.

Growth in Trips

To evaluate the roadway capacity needs and the amount of vehicle trips that are generated by growth, the Metro regional travel demand model was utilized. Table 3-1 shows the projected growth in the number of average daily trip ends, broken down by trip ends that have both an origin and destination within the County's SDC collection area (internal-internal), and trip ends that have one end outside of the County's SDC collection area (internal-external & external-internal). The total projected number of average daily trip ends is 471,812.

Table 3-1
Model Vehicle Trip Ends Growth (Average Daily)[1]

	Internal-Internal	Internal-External & External-Internal	Total
Growth Trip Ends	**110,530**	**361,282**	**471,812**
[1] Based on Metro Regional Travel Model; Daily trips 8.5% of PM Peak Hour trips			

Growth Share of Project Costs

A key component of the TSDC methodology is determining growth's share of future facility improvement costs from the TSDC Project List. According to statutory requirements:

> Improvement fees must be based on a methodology that demonstrates consideration of the projected cost of capital improvements needed to increase system capacity to meet the needs of future users [ORS 223.304]. Furthermore:
>
> *"An increase in system capacity may be established if a capital improvement increases the level of performance or service provided by existing facilities or provides new facilities. The portion of the improvements funded by improvement fees must be related to the need for increased capacity to provide service for future users." [ORS 223.307(2)]*

Table 3-1 presented the system-wide capacity requirements of growth; however, for purposes of determining potential SDC-eligibility, individual projects from the TSDC Capital Project List are analyzed to determine the portion of costs needed for future growth capacity versus costs associated with raising the level of service for existing development.

Two general methods are used for project cost allocations:

1. **"Standards –Based" Approach (used for new facilities and expansion of existing facilities for capacity needs only) –** Existing development paid for existing facilities; new development will pay for its share of system capacity thru funding the next increment of expansion, less costs associated with correcting any existing deficiency. Deficiencies are evaluated based on current performance relative to the appropriate planning/design standard for the particular improvement. For roadways and intersections, the standard is a "volume-capacity ratio (v/c ratio)"[1]. For multimodal improvements, the standard is miles per capita of bikeways and pedestrian ways.
2. **"Capacity Utilization" Approach (used for upgrades to existing facilities to improve level of performance) –** Improvements to existing facilities to address safety, modernization, and other performance considerations provide capacity for growth and enhanced performance for existing development, so the costs are allocated in proportion to the utilization of the facilities (as measured by growth's share of future trips specific to a facility).

Application of the growth share approaches is discussed in more detail below.

New Roadway and Intersection Facilities; Existing Facility Expansion (Capacity Only)

New roadways and expansions driven by future development capacity requirements are allocated 100% to growth, since the capacity is needed entirely for new development.

Similarly, new facilities at intersections (e.g., turn lanes and signals) that are not needed to meet existing mobility standards, but are needed once the growth trips are added to the intersection, are assumed to be 100% funded by growth, since there is no existing deficiency.

Data was compiled from recently completed studies (e.g., the TSP and CRC studies) to determine if facilities were operating with a volume/capacity ratio less than the required standard.

[1] Volume-to-capacity ratio is defined as the ratio between the PM peak hour motor vehicle trips divided by the hourly capacity of the facility to serve those trips.

Upgrades to Roadways and Intersections (Improved Level of Performance)

For upgrade of existing facilities (i.e., realignments, modernization of rural roads, and other improvements), trip volume data by roadway link (from the regional travel demand model) were used to quantify growth's utilization of future roadway and intersection capacity.

Growth capacity utilization is estimated based on the growth in trips over the planning period, as a percentage of total future trips for individual roadway links.

New Multimodal Facilities

Unlike roadway and intersection projects, trip data for bike and pedestrian improvements is not available. Therefore, growth capacity needs for bike and pedestrian facilities are evaluated based on the planned level of service (LOS). The planned LOS is defined as the quantity of future facilities per capita served.

The following equation shows the calculation of the planned LOS:

$$\frac{Existing Q + Planned Q}{Future\ Population\ Served} = Planned\ LOS$$

Where:

Q = quantity (miles of bike or pedestrian facilities), and
Future Population Served = 183,678 (unincorporated Clackamas County only[2])

The existing and future miles of bike and pedestrian facilities are shown in Table 3-2.

Table 3-2
Existing and Future Bike and Pedestrian Facilities (miles)

	Existing	**New** (TSDC Capital Project List)	**New** (Other Funding Sources)	**Future** **(Total)**
Bicycle Lanes	96.1	21.2	12.3	129.6
Bicycle Shoulders	45.9	90.1	0.0	135.9
Pedestrian Facility	114.5	39.5	14.7	168.7

Population data for the estimated base year (2015) and future year (2025) are presented in Table 3-3. Growth during the planning period is estimated to be 17,441.

Table 3-3
Population Growth (Unincorporated Clackamas County)

	Base Year (2015)	**Future Year (2025)**	**Population Growth**
Population	166,237	183,678	17,441
Source: 2015 population based on Metro 2040 Household Forecast; 2025 estimated based on 2040 forecast (adjusted for 10-year period)			

[2] For purposes of the active mode LOS analysis, a 10-year planning period was assumed per County staff, reflecting the TSDC Capital Project List prioritization period.

Table 3-4 presents the existing and planned LOS for bike and pedestrian facilities, based on the existing and planned future facilities presented in Table 3-2 divided by the estimated existing and projected population presented in Table 3-3. (For purposes of this analysis, population figures are divided by 1,000 in order to show the planned LOS per 1,000 population in Table 3-4.)

Table 3-4
Existing and Planned LOS (miles per 1,000 population)

	Existing LOS	Planned LOS
Bike Lanes	0.58	0.71
Bike Shoulders	0.28	0.74
Pedestrian Facility	0.69	0.92

The capacity requirements, or number of miles, needed for the existing population and for the growth population are estimated by multiplying the planned (future) LOS for each facility type (from Table 3-4) by the estimated population (in 1,000's) of each group (from Table 3-3).

These calculations are shown in Table 3-5; each column is then described following the table.

Table 3-5
Existing and Growth Capacity Needs for Bike and Pedestrian Facilities (Miles)

	Existing Population Need (1)	Existing Inventory + Other Sources (2)	Existing Need from TSDC Project Improvements (3)	Growth Need from TSDC Project Improvements (4)
Bike Lanes	117.3	108.4	8.9	12.3
Bike Shoulders	123.0	45.9	77.1	12.9
Pedestrian Facility	152.7	129.3	23.4	16.0

(1) Existing Population Need

The need for the existing population is equal to the planned LOS multiplied by the estimated base year population in 1,000's (166.237).

(2) Existing Inventory + Other Sources

Existing users' needs are assumed to be met first by the existing inventory of facilities, plus facilities funded through other (non TSDC) sources; Table 3-5 (column 2) shows the sum of existing facility and new miles (from other funding sources) from Table 3-2.

(3) Existing Need from TSDC Project Improvements

The difference between columns 1 and column 2 is the portion of existing development's need that will be met by the TSDC Capital Project List improvements.

(4) Growth Need from TSDC Project Improvements

The total capacity need required by growth is equal to the planned LOS (from Table 3-4) multiplied by the projected increase in population over the planning period in 1,000's (17.441).

Table 3-6 shows the distribution of existing and growth allocation for the total planned improvements by project type. For growth, the allocated improvements are assumed to equal the total growth need (from Table 3-5).

Table 3-6
Existing and Growth Share of TSDC Project List Improvements

	Total Planned Improvements (TSDC Project List)	Existing Share	Existing %	Growth Share	Growth %
Bike Lanes	21.2	8.9	42%	12.3	58%
Bike Shoulders	90.1	77.1	86%	12.9	14%
Pedestrian	39.5	23.4	59%	16.0	41%

As shown in Table 3-6, the growth share ranges from 14% for bike shoulders to 58% for additional bike lanes.

Compliance Charge

Local governments are entitled to include in the TSDCs, a charge to recover costs associated with complying with the SDC statutes. Compliance costs include costs related to developing and administering the SDC methodology, project list (including but not limited to TSP and other studies), and credit system; as well as annual accounting costs.

The compliance charge per trip is estimated to be 3% of the base TSDC cost. Table 3-7 shows the calculation of the compliance charge per trip, which is about $13.50.

Table 3-7
Compliance Costs

Category	**Annual $**
County Administration	$80,000
SDC Methodology (1)	$66,000
TSP (2)	$66,000
Total Compliance Costs per Year	$212,000
Estimated Annual Growth Trips	15,727
Compliance Cost per Trip	**$13.48**
(1) Annual costs reflect amortization of total cost over 5 years (2) Growth share of TSP costs amortized over 10 years	

System-wide Unit Cost

The total growth costs reflect the calculated growth share of individual projects from the TSDC Capital Project List; detailed information on the SDC project costs and growth share by mode is provided in Table A-1 of Appendix A. The growth share percentages reflect the approaches described above for each project type and mode.

As shown in Table 3-8, the total growth-related improvement costs are estimated to be $210.3 million. Dividing the total TSDC-eligible costs by the projected growth in Average Daily Trips (from Table 3-1), the system-wide average cost per trip end is $446.

Adding the compliance charge calculated in Table 3-7, brings the total cost per trip to $459, as shown in Table 3-8.

Table 3-8
System-Wide Cost per Trip

Item	Amount
Total TSDC Eligible Costs (1)	$210,308,676
Growth Trip Ends (2)	471,812
SDC per Trip End	**$446**
Cost per Trip End with Compliance Charge (3%)	**$459**

(1) From Project List (Appendix A)
(2) Unincorporated Clackamas County (from Table 3-1; based on regional traffic model)

TSDC Assessment

The transportation SDC for an individual development is based on the cost per trip and the number of trips attributable to that particular development, where the number of trips is computed as follows:

Number of Development Trips =

Traffic Impact Measure X Adjustment Factor(s) X Development Units

Calculating the final TSDC assessment requires the review of multiple components: the traffic impact measure, identifying appropriate traffic impact adjustments, establishing the land use categories and consideration of any discounts available under the program. Each of these components are discussed in more detail below.

The proposed TSDC Rate Schedule is shown in Appendix B in Table B-1.

Traffic Impact Measure

TSDCs are one-time fees assessed to new or expanded developments to help cover the cost of adding capacity to transportation facilities (for motorists, bicyclists and pedestrians) to accommodate new trips generated by the development. TSDC fees are based on the number of trips a particular land use generates, and are paid by the developer when a building permit is issued.

The updated and current methodology uses "Average Daily Trips" as the basis for the TSDC assessment. Under this approach, TSDCs reflect the total traffic added by the development throughout an average weekday. TSDCs based on average daily trips recognize the overall system capacity use of the different types of land uses.

Traffic Impact Adjustments

The current methodology adjustments for trip length have been eliminated, as available data to reasonably estimate average trip length for a given land use type in comparison to other uses is extremely limited. Trip length is attributable to location within an area and the availability of other similar uses in the area, not simply the type of use.

The updated methodology includes pass-by and diverted linked trip adjustments only.

The updated methodology adjustments are discussed in more detail below.

Pass-by Trips

Pass-by trips refer to trips that occur when a motorist is already on the roadway, such as a traveler stopping by a fast-food restaurant on the way home from work. In this case, the motorist making a stop while "passing by" is counted as a trip generated by the restaurant, but it does not represent a new (or primary) trip on the roadway.

Pass-by trip adjustments in the updated methodology are based on published data by land use from the Institute of Transportation Engineers (ITE).

Diverted Link Trips

Diverted Link trips are another type of non-primary trip. In this case, the motorist will divert from a primary route to access a nearby use (e.g., a vehicle may turn off a major roadway onto an intersecting street to access a land use), and then return to the original route to complete the trip.

As with the pass-by trip adjustments, the diverted link trip adjustments included in the updated methodology are based on reported ITE data.

Land Use Categories

The current methodology includes 94 separate rate categories based on development (or land use type). The updated methodology is based on consolidated land use categories (e.g., different types of schools in a single education category, different types of industrial in another, etc.).

Table B-1 (in Appendix B) includes the updated TSDC rates and traffic impact assumptions for the new categories, but also indicates which land use codes from the ITE Trip Generation Manual have been consolidated into the general categories. The new methodology reduces the number of specific rates and would eliminate the need to capture fees on a change of use if the proposed use falls within the same use category.

In determining the traffic impact assumptions for consolidated land use categories, data from the ITE Trip Generation Manual (9th edition) was evaluated.

In some cases, a straight average of the individual trip rates for land uses that comprise the new category was the basis for the assumptions shown in Table B-1.

Trip rates based on less than three traffic studies were eliminated from the averages.

When average daily trips were not available for a particular category, the traffic impact was estimated from the P.M. Peak trip rates, based on a system-wide average P.M. Peak percent of average weekday trips of 8.5%.

For land uses that are not explicitly identified in Table B-1, County staff will make a determination of the appropriate TSDC rate, based on the specific use.

The updated TSDC ordinance will also specify parameters for individual traffic studies.

Single Family Residential TSDCs by Dwelling Size Category

Oregon Household Activity Survey (OHAS) data were used to develop a tiered single family residential SDC structure, based on dwelling unit size, as measured by square footage. The OHAS data analyzed were limited to single family residential observations located in Clackamas County or elsewhere within the Portland metropolitan area with similar densities and dwelling sizes to those in Clackamas County.

From the OHAS information, vehicle trip rates by household size (i.e., number of people) were calculated. These data were then spatially linked to the Regional Land Information System (RLIS) tax lot data, which provides information about dwelling square footage. From this analysis, household vehicle-trip rates by dwelling size were calculated.

Data on County single family residential building permits since 2010 were then used to determine the historical distribution of new dwellings by size (based on square footage of living space, excluding garage and deck space) for selection of three dwelling size categories. In addition to the permit data, consideration was also given to the degree to which average trip rates for different square footage categories were statistically different within various square footage groupings with adequate sample sizes.

Unlike trip rates from ITE, the trip generation information from household survey data include travel generated from household members only and exclude trips made by visitors, including friends, deliveries, and service workers. Because of this difference between trip generation data sources, the rates calculated from household travel surveys are used to create *relative* adjustments to the current fee schedule. The resulting trip rate adjustments for each dwelling size category are shown in Table 3-9.

These adjustments by dwelling size category are applied to the ITE trip rates in the TSDC Rate Schedule (Appendix B, Table B-1) to determine the TSDCs for each Single Family Residential category.

Table 3-9
Single Family Residential Trip Rate Adjustments by Dwelling Category

Dwelling Square Footage Category	<1,700	1,700-2,999	≥3,000
Avg. (weighted) Vehicle Trip Rate [1]	3.70	4.22	4.46
Relative Adjustment [2]	87.5%	99.8%	105.4%

[1] Source: 2011 OHAS & RLIS
[2] Source: Computed from analysis of OHAS & RLIS and Regional Average Trip Rate of 4.23 trips

Accessory Dwelling Unit (ADU) TSDCs by Dwelling Size Category

Few observations exist in existing travel model data for smaller homes comparable to ADUs. Therefore, the proposed TSDCs for two size categories of ADUs are based on the ITE trip rates Condo/Townhomes, as follows:

- Large ADU 450 -900 square feet = 100 percent of Condo/Townhome trip rate
- Small ADU 450-200 square feet = 50 percent of Condo/Townhome trip rate

The TSDC Rate Schedule (Appendix B, Table B-1) shows the proposed ADU trip rates and TSDCs based on current ITE data.

TSDC Discounts

The County currently provides a system of TSDC discounts for qualifying developments. Specifically, discounts apply as follows:

- Mixed-use development can receive reductions of 7-18%, depending on floor area ratio (FAR) and residential/retail/commercial mixtures on the site.
- Transit oriented development can receive reductions of 5-20% depending on floor area ratio (FAR), proximity to transit, and type of transit system. This discount applies only to permanent transit routes/lines, such as SAM, CAT, SMART, or TriMet.

No changes to the current discounts are proposed under the new methodology.

Annual Inflationary Adjustments

The fees included in the Proposed TSDC Rate Schedule will be adjusted annually based on an inflationary index as specified in the County TSDC ordinance. The County intends to use the Engineering News Record (ENR) Northwest (Seattle, Washington) Construction Cost Index as the basis for adjusting the TSDCs.

Appendix A – TSDC Capital Project List

Table A-1
Clackamas County Draft TSDC Project List 2017

PROJECT DETAILS						SDC ELIGIBLE	
#	Location	Project	Segment/Location	Description	Total Project Cost	Total % Eligible	Total $ Eligible
1004	Urban	122nd Ave	Sunnyside Rd to Timber Valley Dr	Add bikeways and turn lanes at major intersections	$3,010,000	62.04%	$1,867,496
1006	Urban	142nd Ave	Sunnyside Rd to OR 212	Add bikeways and pedways	$14,060,000	51.53%	$7,245,291
2017	Rural	362nd Ave	Skogan Rd to OR 211 (excludes state facilities)	Add paved shoulders	$5,980,000	29.40%	$1,758,120
AI S1	Urban	82nd Avenue	82nd Ave/Hinkley (excludes state facilities)	Install traffic separator on 82nd Avenue to convert accesses at SE Hinckley at Columbia Bank/Union 76 on east side of 82nd Avenue to right-in/right-out. Create new circulation to route traffic to signal at SE Lindy.	$4,182	24.00%	$1,009
AI S2	Urban	82nd Avenue	82nd Ave MP 8.50 (excludes state facilities)	In the vicinity of MP 8.50 put in enhanced pedestrian crossing to connect east side pedestrian ramp with walkway to neighborhood to west.	$82,000	9.00%	$7,786
AI S4	Urban	82nd Avenue	82nd Ave North entrance to Clackamas Town Center (excludes state facilities)	North entrance to Clackamas Town Center on 82nd make right in, right out only and remove signal. Perform traffic analysis as needed to evaluate traffic diversion to adjacent roadways and intersections.	$69,700	24.00%	$16,503
AI S5	Urban	82nd Avenue	Sunnyside to 82nd Ave (excludes state facilities)	Install double left, westbound Sunnyside to southbound 82nd Ave (east to south). Add median island for pedestrian crossing. Standardize NB right-turn lane 82nd to Sunnyside, including bike lane.	$734,891	79.00%	$583,169
AI S7	Urban	82nd Avenue	Sunnyside Rd to Sunnyside Dr	Install traffic separator from Sunnyside Rd to Sunnyside Dr (MP 9.15), advance street names.	$17,712	24.00%	$4,185
AI S8	Urban	82nd Avenue	82nd Ave Monterey to Harmony/Sunnyside (excludes state facilities)	Traffic separator Monterey to Harmony/Sunnyside.	$98,400	24.00%	$23,299
1008	Urban	82nd Dr	OR 212 to Lawnfield Rd	Fill in bikeways and pedways gaps	$680,000	40.60%	$276,106

Table A-1 (Continued)
Clackamas County Draft TSDC Project List 2017

PROJECT DETAILS						SDC ELIGIBLE	
#	Location	Project	Segment/Location	Description	Total Project Cost	Total % Eligible	Total $ Eligible
1009	Urban	85th Ave	Causey Ave to Monterey Ave	Add sidewalks and bikeways. Perform Pedestrian Safety Audit to verify lighting, crosswalk striping and signing at Causey Ave.	$30,000	47.77%	$14,332
1010	Urban	92nd Ave	Johnson Creek Blvd to Emmert View Ct	Fill gaps in pedways	$480,000	40.60%	$194,898
AI S12	Urban	97th Avenue	Sunnybrook Blvd to Mather Rd	Investigate improved striping including outside fog lines, and rumble striping. Verify lighting, drainage, surface friction. From Sunnybrook Blvd to Mather Rd	$49,200	35.00%	$17,193
1049	Rural	Amisigger Rd / Kelso Rd	OR 224 to Kelso / Richey Rd (excludes state facilities)	Add paved shoulders; turn lanes at Amisigger/OR 212 and Kelso/Richey; smooth curves.	$13,010,000	57.05%	$7,422,839
2029	Rural	Arndt Rd Extension	Barlow to OR 99E (excludes state facilities)	Construct new 2 or 3 lane roadway	$17,040,000	100.00%	$17,040,000
2030	Rural	Barlow Rd	Knights Bridge Rd to OR 99E	Add paved shoulders	$5,400,000	19.97%	$1,078,492
1097	Rural	Beavercreek Rd	Henrici Rd to Yeoman Rd/Steiner Rd	Add paved shoulders and turn lanes at major intersections	$11,630,000	16.25%	$1,890,216
AI S9	Urban	Bob Schumacher Road	Bob Schumacher Road	Investigate improved striping, including centerline rumble stripe.	$49,200	30.00%	$14,765
1081	Rural	Borland Rd	Tualatin city limits to Stafford Rd	Add paved shoulders in accordance with the Active Transportation Plan and turn lanes at major intersections	$5,680,000	30.59%	$1,737,528
1082	Rural	Borland Rd	Stafford Rd to West Linn city limits	Add paved shoulders	$10,290,000	43.23%	$4,448,713
1013	Urban	Boyer Dr / 85th Ave / Spencer D	OR 213 to I-205 bike path (excludes state facilities)	Add bikeways	$40,000	57.96%	$23,183
1099	Rural	Canby-Marquam Highway	Canby-Marquam Hwy / Lone Elder Rd intersection	Reconstruct intersection; install northbound left-turn lane and southbound right-turn lane	$3,850,000	30.77%	$1,184,615
1014	Urban	Causey Ave	Fuller Rd to I-205 (excludes state facilities)	Add bikeways and shared facility markings in accordance with the Active Transportation Plan.	$50,000	57.96%	$28,979
AI S6	Urban	Causey Avenue	Causey Ave/85th Ave	Pedestrian Safety Audit - verify lighting, crosswalk striping, signing, at Causey Ave/85th Ave	$30,750	9.00%	$2,920
1101	Rural	Clarkes Four Corners Intersecti	Beavercreek Rd / Unger Rd	Reconstruct intersection	$4,490,000	17.14%	$769,714

Table A-1 (Continued)
Clackamas County Draft TSDC Project List 2017

PROJECT DETAILS						SDC ELIGIBLE	
#	Location	Project	Segment/Location	Description	Total Project Cost	Total % Eligible	Total $ Eligible
2001	Urban	Clatsop St / Luther Rd	72nd Ave to Fuller Rd	Add turn lanes and signals at OR 213 intersection; add bikeways, pedways and traffic calming	$8,118,000	47.93%	$3,891,198
1062	Urban	Concord Rd	River Rd to Oatfield Rd	Fill gaps in pedway	$7,410,800	40.60%	$3,009,065
1063	Urban	Courtney Ave	OR 99E to Oatfield Rd (excludes state facilities)	Fill gaps in pedestrian facilities and bikeways	$1,860,000	48.86%	$908,737
1064	Urban	Courtney Ave	River Rd to OR 99E (McLoughlin Blvd) (excludes state facilities)	Construct pedestrian facilities / complete gaps on the south side; add bikeways	$5,010,000	42.88%	$2,148,400
2034	Rural	Dryland Rd	Macksburg Rd S to Macksburg Rd N	Realign to form one intersection at Dryland Rd	$3,400,000	26.25%	$892,500
1055	Rural	Eagle Creek Rd	Currin Rd to Duus Rd	Remove horizontal curve, relocate intersection, add paved shoulders and turn lanes at major intersection; investigate speed zone south of Currin Rd	$10,500,000	53.43%	$5,610,294
2018	Rural	Eagle Creek Rd	OR 211 to Duus Rd (excludes state facilities)	Add paved shoulders	$14,780,500	21.67%	$3,202,442
2002	Urban	Evelyn St	OR 224 to Jennifer St (excludes state facilities)	Add bikeways and pedways	$1,681,000	40.84%	$686,599
2019	Rural	Firwood Rd	Wildcat Mountain Dr to US 26	Add paved shoulders and turn lanes at major intersections.	$16,840,000	17.50%	$2,947,000
1019	Urban	Flavel Dr	Alberta Ave to County boundary	Add bikeways in accordance with the Active Transportation plan	$2,410,000	57.96%	$1,396,796
1085	Urban	French Prairie Bridge	Willamette River near I-5 (excludes state facilities)	Construct a bridge in accordance with the Active Transportation Plan	$9,790,000	20.78%	$2,034,242
1020	Urban	Fuller Rd	Otty St to Johnson Creek Blvd	Add pedestrian facilities, turn lanes, on-street parking, central median and landscaping.	$7,580,000	67.88%	$5,145,111
1022	Urban	Harmony Rd	OR 213 to OR 224	Construct bikeways and pedways	$9,760,000	48.40%	$4,724,074
2035	Rural	Hattan Rd	Fischers Mill Rd to Gronlund Rd	Add paved shoulders and turn lanes at major intersections	$15,426,300	45.50%	$7,018,339
1108	Rural	Henrici Rd	Beavercreek Rd to Ferguson Rd	Add paved shoulders and turn lanes at major intersections. Remove horizontal and vertical curves	$4,900,000	46.15%	$2,261,538
2036	Rural	Henrici Rd	OR 213 to Beavercreek Rd (excludes state facilities)	Add paved shoulders and turn lanes at major intersections	$5,196,800	44.67%	$2,321,284

Table A-1 (Continued)
Clackamas County Draft TSDC Project List 2017

PROJECT DETAILS						SDC ELIGIBLE	
#	Location	Project	Segment/Location	Description	Total Project Cost	Total % Eligible	Total $ Eligible
2037	Rural	Henrici Rd	Ferguson Rd to Redland Rd	Add paved shoulders and turn lanes at major intersections. Remove horizontal and vertical curves	$17,870,000	43.79%	$7,824,507
1066	Urban	Hull Ave	Wilmot St to Tims View Ave	Fill gaps in pedestrian facilities	$4,130,000	40.60%	$1,676,936
3013	Urban	I-205 Ped / Bike Overpass	Between Causey Ave and Sunnyside Rd	Construct a bike / ped crossing over I-205 to connect transit services, businesses and residents	$4,900,000	20.78%	$1,018,160
2005	Urban	Jennifer St	82nd Dr to 135th Ave (excludes state facilities)	Add pedways	$16,082,300	40.60%	$6,530,022
2021	Urban	Jennings Ave	Oatfield Rd to Webster Rd	Widen to 2-lane urban minor arterial standard with bikeway and pedway infill	$13,659,827	66.19%	$9,041,080
1030	Urban	Johnson Creek Blvd	Johnson Creek Blvd / OR 213 intersection (excludes state facilities)	Extend westbound left-turn lane and rebuild median; install dual northbound and southbound left-turn lanes	$890,000	100.00%	$890,000
Al MV3	Urban	Johnson Creek Boulevard	92nd/Johnson Creek Blvd	Turn lane improvements at 92nd/Johnson Creek Boulevard	$467,400	14.00%	$66,545
2022	Urban	Lake Oswego to Milwaukie Brid	Between Sellwood and Oregon City	Construct bike/pedestrian crossing over the Willamette River in accordance with the Active Transportation Plan	$10,130,000	20.78%	$2,104,890
2006	Urban	Lake Rd	Milwaukie City limits east to OR 224 (excludes state facilities)	Fill gaps in pedways	$5,670,000	40.60%	$2,302,234
2007	Urban	Linwood Ave	Linwood Ave / Monroe St intersection	Add curbs/sidewalks, improve horizontal alignments	$7,605,500	31.54%	$2,398,729
1112	Rural	Lone Elder Rd Bridge	~5,800 feet east of Barlow Rd	Replace bridge (nearing the end of its useful life) and include paved shoulders	$450,000	15.00%	$67,500
1115	Rural	Molalla Ave Flooding	Just south of city of Molalla	Construct bridge to resolve flooding issues	$720,000	44.86%	$322,971
2010	Urban	Monroe St / 72nd Ave / Thomps	Linwood Ave to Fuller Rd	Add pedestrian facilities	$3,970,000	40.60%	$1,611,970
Al MV2	Urban	Monterey Ave	Monterey Ave	North-south roadway between project Al MV1 and Monterey Ave	$4,258,545	100.00%	$4,258,545
2039	Rural	Mulino Rd (13th St segment)	Canby city limits to OR 213 (excludes state facilities)	Add paved shoulders and turn lanes at major intersections	$24,890,000		$13,498,038
1069	Urban	Oak Grove Blvd	Oatfield Rd to River Rd	Fill gaps in pedways and bikeways	$2,590,000	44.32%	$1,147,763

Table A-1 (Continued)
Clackamas County Draft TSDC Project List 2017

PROJECT DETAILS						SDC ELIGIBLE	
#	Location	Project	Segment/Location	Description	Total Project Cost	Total % Eligible	Total $ Eligible
1071	Urban	Oatfield Rd	Oatfield Rd / Park Rd intersection	Install traffic signal and add turn lanes	$1,060,000	32.56%	$345,116
1072	Urban	Oatfield Rd	Oatfield Rd / McNary Rd intersection	Add southbound and eastbound left-turn lanes	$570,000	20.16%	$114,912
1041	Urban	Otty Rd	Fuller Rd to 92nd Ave	Improve consistent with Fuller Road Station Plan; improve curb radius; add turn lanes, on-street parking, central median, landscaping, bikeways and pedestrian facilities. Install pedestrian crossing between Fuller Rd and I-205 and near 91st Ave.	$1,216,000	50.39%	$612,765
1073	Urban	Park Ave	River Rd to OR 99E (McLoughlin Blvd)	Add pedestrian facilities	$1,750,000	40.60%	$710,566
2042	Rural	Redland Rd	Redland Rd / Fischers Mill Rd / Henrici Rd intersection	Install eastbound left-turn, eastbound right-turn and westbound right-turn lanes at Henrici Rd	$860,000	39.78%	$342,141
1058	Rural	Richey Rd	Kelso Rd to OR 212 (excludes state facilities)	Add paved shoulders and left turn lane at Richey Rd and OR 212	$4,200,000	49.52%	$2,079,756
1074	Urban	River Rd	Lark St to Courtney Ave	Add pedways	$4,880,000	40.60%	$1,981,465
1075	Urban	River Rd	Oak Grove Blvd to Risley Ave	Fill gaps in bikeways and pedways	$5,710,000	42.14%	$2,406,226
2023	Urban	Roots Rd	Webster Rd to McKinley Rd	Add pedways	$4,838,000	40.60%	$1,964,411
1086	Rural	Rosemont Rd	Stafford Rd to West Linn	Add paved shoulders and turn lanes at major intersections	$8,790,000	29.28%	$2,573,402
1125	Rural	Springwater Rd	Hattan Rd to Bakers Ferry Rd	Add paved shoulders and turn lanes at major intersections	$6,330,000	33.54%	$2,123,279
1088	Rural	Stafford Rd	Rosemont Rd to I-205 (excludes state facilities)	Add paved shoulders and turn lanes at major intersections	$8,600,000	35.62%	$3,062,991
2028	Rural	Stafford Rd / 65th Ave	I-205 to Boeckman Rd / Advance Rd (excludes state facilities)	Add paved shoulders and turn lanes at major intersections	$22,078,500	46.18%	$10,196,598
Al MV1	Urban	Stevens Road	Stevens Rd to High Creek Rd	East-west roadway connecting Stevens Road to High Creek Road. Include sidewalk and bike lanes	$9,414,874	77.00%	$7,288,420

Table A-1 (Continued)
Clackamas County Draft TSDC Project List 2017

PROJECT DETAILS						SDC ELIGIBLE	
#	Location	Project	Segment/Location	Description	Total Project Cost	Total % Eligible	Total $ Eligible
2015	Urban	Sunnyside Rd	OR 213 to 97th Ave	Modified boulevard treatment including lane redesign, medians, beautification, curb extensions, reconstructed sidewalks, landscaping, south side bikeways. Consider flashing yellow arrow for left-turns at signalized intersections.	$5,330,000	19.92%	$1,061,986
1077	Urban	Thiessen Rd	Thiessen Rd / Aldercrest Rd intersection	Add turn lanes on Thiessen Rd; consider converting to two-way stop controlled	$570,000	20.42%	$116,366
2024	Urban	Thiessen Rd	Oatfield Rd to Webster Rd	Add bikeways and pedways	$24,425,800	50.85%	$12,419,625
2025	Urban	Webster Rd	OR 224 to Gladstone (excludes state facilities)	Fill gaps in bikeways and pedways	$19,485,300	46.47%	$9,053,989
1059	Rural	Welches Rd	US 26 to Birdie Ln (excludes state facilities)	Add paved shoulders; add pedestrian facilities in Welches rural center; evaluate pedestrian crossing near Stage Stop Rd; add multi-use path	$6,360,000	19.59%	$1,245,800
Total Project Count		**76**			**$476,271,481**	**44.16%**	**$210,308,676**

Appendix B – Proposed TSDC Rate Schedule

Table B-1
TSDC Rate Schedule

Land Use Category	Units	ITE Codes Included	Traffic Impact[1,2]	Adjustments		Adjusted Traffic Impact	Updated TSDC per Unit[3]	Updated TSDC per Unit[3] [Effective 07-01-19; 4.9307% CPI Increase]
				% Diverted Link Trips	Pass-by %			
Transit Parking	Parking Space	90, 93	4.50	-	-	4.50	$2,068	**$2,170**
Industrial/ Manufacturing/Warehouse	1,000 Gross Square Feet	110, 120, 130,140, 150, 151, 170	4.21	-	-	4.21	$1,936	**$2,031**
Small Detached Single-Family Home (dwelling units 1,699 square feet or less)	Dwelling Unit	210	9.52	-	-	8.33	$3,827	**$4,016**
Medium Detached Single-Family Home (dwelling units 1,700-3,000 square feet)	Dwelling Unit	210	9.52	-	-	9.50	$4,366	**$4,581**
Large Detached Single-Family Home (dwelling units more than 3,000 square feet)	Dwelling Unit	210	9.52	-	-	10.03	$4,610	**$4,838**
Apartment	Dwelling Unit	220	6.65	-	-	6.65	$3,056	**$3,206**
Residential Condo/Townhouse	Dwelling Unit	230	5.81	-	-	5.81	$2,670	**$2,801**
Small Accessory Dwelling Unit (200-449 square feet)	Dwelling Unit	220	5.81	-	-	5.81	$2,670	**$2,801**
Large Accessory Dwelling Unit (450-900 square feet)	Dwelling Unit	220	5.81	-	-	2.91	$1,335	**$1,401**
Mobile Home in Park	Space	240	4.99	-	-	4.99	$2,293	**$2,406**
Assisted Living	Beds	254, 620	2.70	-	-	2.70	$1,241	**$1,302**
Senior Housing	Dwelling Unit	251, 253, 255	3.06	-	-	3.06	$1,404	**$1,473**
Hotel/Motel	Room	310, 320	8.17	-	-	8.17	$3,754	**$3,939**

Table B-1 (Continued)
TSDC Rate Schedule

Land Use Category	Units	ITE Codes Included	Traffic Impact[1,2]	Adjustments		Adjusted Traffic Impact	Updated TSDC per Unit[3]	Updated TSDC per Unit[3] [Effective 07-01-2019; 4.9307% CPI Increase]
				% Diverted Link Trips	Pass-by %			
Parks	Acre	411, 412	2.09	-	-	2.09	$958	**$1,005**
Campground/RV Park	Site	416	*2.30*	-	-	*2.30*	$1,055	**$1,107**
Marina	Berths	420	2.96	-	-	2.96	$1,360	**$1,427**
Golf Course	Holes	430	35.74	-	-	35.74	$16,422	**$17,232**
Golf Driving Range	Tee/ Drive Position	432	*10.63*	-	-	*10.63*	$4,882	**$5,123**
Recreation Community Center	1,000 Gross Square Feet	435, 495	33.82	-	-	33.82	$15,540	**$16,306**
Bowling Alley	Bowling Lanes	437	12.84	-	-	12.84	$5,897	**$6,188**
Movie Theater	Movie Screens	443, 444, 445	115.94	-	-	115.94	$53,272	**$55,899**
Casino/Video Lottery Establishment	1,000 Gross Square Feet	473	114.16	-	-	114.16	$52,452	**$55,038**
Soccer Complex	Field	488	71.33	-	-	71.33	$32,775	**$34,391**
Racquet/Tennis Club	Court	491	38.70	-	-	38.70	$17,782	**$18,659**
Health/Fitness Club	1,000 Gross Square Feet	492	30.01	-	-	30.01	$13,787	**$14,466**
Military Base	Employees	501	1.78	-	-	1.78	$818	**$858**
Education	Student	520, 522, 530, 536, 540, 550	1.51	-	-	1.51	$695	**$729**
Church	1,000 Gross Square Feet	560	9.11	-	-	9.11	$4,186	**$4,392**
Day Care	Student	565	4.38	56	-	1.93	$886	**$929**
Library	1,000 Gross Square Feet	590	56.24	-	-	56.24	$25,841	**$27,115**

Table B-1 (Continued)
TSDC Rate Schedule

Land Use Category	Units	ITE Codes Included	Traffic Impact[1,2]	Adjustments		Adjusted Traffic Impact	Updated TSDC per Unit[3]	Updated TSDC per Unit[3] [Effective 07-01-2019; 4.9307% CPI Increase]
				% Diverted Link Trips	Pass-by %			
Hospital	Beds	610	12.94	-	-	12.94	$5,946	**$6,239**
Medical-Dental	1,000 Gross Square Feet	720, 630	36.13	-	-	36.13	$16,601	**$17,420**
Office	1,000 Gross Square Feet	710, 714, 715, 730, 750, 760, 770	10.44	-	-	10.44	$4,796	**$5,033**
State Motor Vehicles Department	1,000 Gross Square Feet	731	166.02	-	-	166.02	$76,283	**$80,044**
Post Office	1,000 Gross Square Feet	732	108.19	-	17	89.80	$41,260	**$43,295**
Building & Hardware	1,000 Gross Square Feet	812, 816	48.23	-	37	30.72	$14,115	**$14,811**
Free-Standing Discount Store	1,000 Gross Square Feet	813, 815	54.00	35	22	23.38	$10,743	**$11,272**
Nursery	1,000 Gross Square Feet	817, 818	68.10	-	34	44.95	$20,652	**$21,670**
Factory Outlet Center	1,000 Gross Square Feet	823	26.59	-	34	17.55	$8,064	**$8,461**
Automobile Sales	1,000 Gross Square Feet	841	32.30	-	34	21.32	$9,795	**$10,278**
Automobile Parts Sales	1,000 Gross Square Feet	843	61.91	-	43	35.29	$16,214	**$17,014**
Tire Stores	1,000 Gross Square Feet	848, 849	22.62	-	28	16.28	$7,482	**$7,851**
Supermarket	1,000 Gross Square Feet	850, 854	102.24	38	36	26.58	$12,214	**$12,816**
Convenience Market	1,000 Gross Square Feet	851, 852	612.39	11	51	232.71	$106,924	**$112,196**

Table B-1 (Continued)
TSDC Rate Schedule

Land Use Category	Units	ITE Codes Included	Traffic Impact[1,2]	Adjustments		Adjusted Traffic Impact	Updated TSDC per Unit[3]	Updated TSDC per Unit[3] [Effective 07-01-2019; 4.9307% CPI Increase]
				% Diverted Link Trips	Pass-by %			
Shopping/Retail	1,000 Gross Square Feet Leasable Area	820, 826, 862, 863, 867	43.63	13	34	23.21	$10,665	**$11,191**
Pharmacy	1,000 Gross Square Feet	880, 881	93.49	14	51	33.27	$15,288	**$16,042**
Furniture Store	1,000 Gross Square Feet	890	5.06	-	53	2.38	$1,093	**$1,147**
Bank	1,000 Gross Square Feet	911, 912	148.15	26	35	57.78	$26,548	**$27,857**
Restaurants	1,000 Gross Square Feet	925, 931, 932	108.55	27	44	32.75	$15,048	**$15,790**
Fast Food	1,000 Gross Square Feet	933, 934	496.12	23	50	133.95	$61,548	**$64,583**
Coffee/Donut Shop	1,000 Gross Square Feet	936, 937	818.58	-	89	90.04	$41,373	**$43,413**
Quick Lubrication Veh. Shop	Service Positions	941	44.12	-	42	25.59	$11,757	**$12,336**
Automobile Care Center	1,000 Gross Square Feet	942	26.44	-	42	15.33	$7,045	**$7,392**
Service Stations	Fueling Positions	853, 944, 945, 946	161.39	32	51	27.11	$12,456	**$13,070**

[1] Based on Average Weekday Trips
[2] Italicized daily trip rate calculated as PM
[3] Includes compliance cost

Appendix C – County TSP Cost Estimate Assumptions

CLACKAMAS COUNTY Update
TRANSPORTATION SYSTEM PLAN

Cost Estimate Assumptions

Date: January 7, 2013 Project #: 11732

To: Project Management Team

From: Susan L. Wright, P.E.; Marc A. Butorac, P.E., P.T.O.E.; Kelly M. Laustsen; and Erin M. Ferguson, P.E.; Kittelson & Associates, Inc; Gary Alfson, Otak

Project: Clackamas County Transportation System Plan Update

Subject: Cost Estimate Assumptions

The following list documents the assumptions made in preparing cost estimates for the projects on the Master List for the Clackamas County Transportation System Plan (TSP) Update.

- The unit costs for each roadway classification was computed per lineal foot based on the classification provided in the Functional Classification and Urban or Rural columns in the KAI master spreadsheet and the attached table (Roadway Cost Estimates.xlsx) prepared by Otak.
- The total project costs have been estimated based on the length and roadway classification data provided in the KAI spreadsheet.
- Roadway costs were computed assuming reconstruction of the existing roadway when upgrading to full standards.
- Intersection improvement costs have been estimated using 500 feet per leg of the side street using the Rural Arterial classification section. This length was doubled for state highway intersections.
- Added turn lane costs have been estimated using 500 feet of a left turn lane of Rural Arterial classification, widening only one side of the existing roadway for right turn lanes and both sides for left turn lanes. This length was doubled for state highway intersections.
- For projects that included "turn lanes at major intersections," it was assumed the project will include left turns at all side streets of arterial and collector classifications. The intersections at the beginning and end of the segment were included.
- Driveways and private drives have not been included.

- Projects listed as bikeways have been estimated using the "Bike lane widening, urban" classification, unless otherwise noted. The cost for this item also includes the construction of landscape strips and sidewalks.
- Projects listed as pedways have been estimated using the "Sidewalk widening, urban" classification, unless otherwise noted.
- Projects that listed the percentage of bikeway and pedways already completed have a percentage assigned to the overall length of improvements as follows:
    - 1-25% complete: improve 87.5% of project length
    - 26-50% complete: improve 62.5% of project length
    - 51-75% complete: improve 37.5% of project length
    - Not specified : improve 100% of project length.
- Safety audit costs have been input at $30,000 per mile in urban areas, $15,000 per miles in rural areas.
- Road closure costs have been input at $30,000 each.
- The costs for vertical realignment have not been included.
- The cost for horizontal realignment has not been included beyond the length of the roadway improvements or the 500 foot long leg of intersection improvements.
- The costs for right-of-way have not been included.
- Water quality or detention facilities are not included.
- Wetland impacts or sensitive area mitigation not included.
- The estimated project costs have been taken from the "cost estimate from existing plans" or have not been provided when there is a lack of adequate information to estimate the project.
- Estimates do not include traffic signal retrofit work, irrigation, culvert crossings, retaining walls, or sound walls. These could add significant costs to the project.
- Bridge locations and lengths were estimated from Google Earth images when no other resource was available.
- The undercrossing projects have been estimated using the bridge unit cost.

- Costs for public or franchise utilities are not included (water, sanitary sewer, power, natural gas, cable, telephone).
- Striping assumes thermoplastic materials.
- Signing frequency set at 200' o.c. in urban areas, 400' o.c. in rural areas.
- Earthwork based on 1.25' excavation/embankment across entire ROW. No rock excavation. Assumes 12" stripping (haul-off)
- Pavement section is assumed and may vary based on geotechnical recommendations and traffic volumes.

Detached Single-Family Homes

Tiered Transportation System Development Charge (TSDC) Rates

- PROPOSED -

Detached Single-Family Homes

[Current = $4,590]

PROPOSED:

< 1,700 Sq. Ft.
87.5%
$4,015

1,700 – 2,999 Sq. Ft.
99.8%
$4,579

≥ 3,000 Sq. Ft.
105.4%
$4,840

- ❑ Clackamas County adopted a new TSDC methodology in January 2018.
- ❑ Staff committed to performing an analysis to see if there is a link between home size and number of transportation trips in unincorporated Clackamas County.
- ❑ The study showed that there is a link, so we are proposing a tiered residential rate that reflects this data.
- ❑ Based on permit history, with this proposal the County will collect 98% of the anticipated revenue from the original rates.

Exemptions

[No TSDC Charged]

Additions & Detached Units

≤ 199 Sq Ft.

$0

Accessory Dwelling Units

Tiered Transportation System Development Charge (TSDC) Rates

- PROPOSED -

Accessory Dwelling Units

[Current Multi-Family Rate = $3,207]

PROPOSED:

200 – 450 Sq Ft.

50% of Condo / Townhome Rate

$1,401

450 – 900 Sq. Ft.

100% of Condo / Townhome Rate

$2,802

- Few observations exist in existing travel model data for smaller homes comparable to ADUs.
- The work group recommended lowering the rate for the ADUs given the lack of local data, and the results of the single-family analysis showing reduced trips based on size.
  - Historically, the County has charged the multi-family rate.
  - The proposed TSDCs for ADUs are based on the ITE trip rates Condo/Townhomes.

Exemptions

[No TSDC Charged]

Additions & Detached Units

≤ 199 Sq Ft.

$0

Revised February 14, 2020

Tiered Residential Transportation System Development Charge (TSDC) Program
Workgroup Decision Overview

In November 2018, after hiring a consultant to help facilitate the data review, the County brought together a work group of stakeholders to consider a tiered residential TSDC rate. The group was made up of representatives from the development community, a member of the Home Builders Association (HBA), a county resident interested in developing an Accessory Dwelling Unit (ADU) on their land, and County staff.

The group was tasked with:

- Considering the advantages and limitations of each archived data source that can be used to link trips rates to dwelling size;
- Identifying which residential units would be considered (single family residential (SFR), multifamily, and accessory dwelling units), based on existing assessment policies and selected data sources;
- Identifying the number and scale of dwelling size tiers that best represents a fluctuation in impact, based on the data analysis;
- Looking at the data sources to define the dwelling size measurement (e.g., bedrooms, square footage, living area);
- Process for application of tiers and potential issues or considerations
- Policies related to dwelling additions and conversions

The group met three times between October 2018 and July 2019 to review data and make decisions to review the analysis and refine the recommended program.

<table>
<tr><th>STEP 1</th><th colspan="2">DISCUSSION</th></tr>
<tr><td>Link Trip Rates to Dwelling Size.</td><td colspan="2">The number of trips generated from new development provide the basis of evaluating transportation impacts. The industry standard is to use the ITE Trip Generation Handbook & Trip Generation Manual, which does not consider the urban or social context of the sites. Rates are charged ‘per dwelling unit’.

When considering a tiered residential rate, we would need to consider the number of people living in the dwelling or their characteristics. It can be challenging to develop rates that are sensitive to the number of people, so dwelling size (square footage or number of bedrooms) is often used as a proxy for number of people.</td></tr>
<tr><td colspan="2">OPTIONS:

1) Collect new data from single-family dwellings that include information about number of people or dwelling size; or

2) Use a combination of archived data sources to estimate trips/dwelling unit size.</td><td>DECISION:

Use a combination of archived data sources to estimate trips/dwelling unit size:

1) Use household travel survey data to establish trip rates per household
• Vehicle trips and/or person trips to/from residence
• By household size (# people)

2) Link trips/person to persons/dwelling unit size
• 2a. American Housing Survey: provides information on number of people per housing unit and size of dwelling unit (number of bedrooms, square footage)
• 2b. Regional Land Information System (RLIS): Portland Metro regional tax lot information and assessor's data (square footage of dwelling and lot), street address</td></tr>
</table>

STEP 2	DISCUSSION
Select the household travel survey data to establish trip rates per household.	There are two surveys that can be used to link trips with the number of people, the National Household Travel Survey (NHTS: 2017) and the Oregon Household Activity Survey (OHAS: 2011-12). • NHTS is a National sample (~26,ooo households) and the OHAS is specific to the Portland Metro region (~4400 households) • NHTS has limited location information and the OHAS has detailed spatial information • NHTS does not differentiate between Single Family and Multi-Family dwellings, but the OHAS includes that variable

OPTIONS:	DECISION:
1) Use the National Household Travel Survey (NHTS) to establish trip rates per household; or 2) Use the Oregon Household Activity Survey (OHAS) to establish trip rates.	Use the Oregon Household Activity Survey (OHAS) to establish trip rates. • Large, local trip and housing sample of data • Household information (socio economics, vehicle ownership, etc) • Does not include trip records of visitors, services, other people coming/going from home • Local trip data with location • Can distinguish between SF and MF housing

The workgroup preferred local data that represented the travel behavior of Clackamas County residents. So, they chose to move forward with the OHAS data, which were limited to SFR observations located in Clackamas County or elsewhere within the Portland metropolitan area in areas with similar densities and dwelling sizes to those in Clackamas County.

From the OHAS information, the Consultant Team calculated the home-based vehicle trip rates for a 24-hr period (Monday through Thursday only) by household size (i.e., number of people).

<table>
<tr><th>STEP 3</th><th colspan="2">DISCUSSION</th></tr>
<tr><td>Select the data source that will establish the average number of people in a particular size dwelling unit.</td><td colspan="2">There are two surveys that can be used to identify the average number of people that typically live in a particular size dwelling unit, the American Housing Survey (AHS) and the Regional Land Information System (RLIS).
• AHS is a National sample (~85,ooo housing units) and RLIS is specific to the Portland Metro regional tax lot information and assessor's data
• AHS has the number of people per housing unit, but RLIS does not provide the number of people per unit
• AHS provides the size of the dwelling unit (both number of bedrooms and square footage) and RLIS provides the square footage of the dwelling and the lot
• RLIS also provides the street address, so it could be spatially paired with household survey data</td></tr>
<tr><td colspan="2">OPTIONS:
1) Use the American Housing Survey (AHS) to establish # of people per dwelling unit; or
2) Use Regional Land Information System (RLIS) to establish # people/unit.</td><td>DECISION:
Use Regional Land Information System (RLIS) to establish the number of people per dwelling unit.
• Portland Metro regional tax lot information and assessor's data
• Includes information for square footage of dwelling and lot
• No information on the number of bedrooms
• Limited ability to repeat the analysis for multifamily housing
• Provides a direct link from trip making to dwelling size with street address</td></tr>
</table>

The OHAS data from Step 2 was spatially linked to the RLIS tax lot data, which provides information about dwelling square footage. From this analysis, the household vehicle-trip rates by dwelling size were calculated.

Finally, data on County SFR building permits since 2010 were used to determine the historical distribution of new SFR dwellings by size (based on square footage of living space, excluding garage and deck space).

STEP 4	DISCUSSION
Review policies for program administration and provide recommendations for applying a tiered rate.	Once a rate structure for single family residential (SFR) homes was identified, the workgroup had to formalize decisions regarding the assessment policy: • Would the policy apply to multi-family, single family detached and/or accessory dwelling units? • Number and scale of dwelling size tiers? • Definition of dwelling size (e.g., bedrooms, square footage, living area)? • Identify a process for application of tiers and potential issues or considerations. • Clarify policies related to dwelling additions and conversions.

DECISIONS:

Detached Single Family housing:

- The group recommended an adjustment to the TSDC fee schedule for single-family detached dwellings, with three possible assessments based on the living area (square footage) of the unit. Thresholds for each category were based on:
  1) The historical distribution of dwellings by size (from the permit data),
  2) Degree to which average trip rates were statistically different within various square footage groupings with adequate sample sizes; and
  3) Whether the adjusted schedule would be revenue neutral when compared to the current TSDC structure.
- The group provided a recommendation for a policy that would reduce the rate for Accessory Dwelling Units, which resulted in a tiered rate with two possible assessments based on the square footage of the unit.
- The group recommended that the County exempt up to 199 sq. ft. additions or detached units 199 sq. ft. or smaller.

Multi-Family housing:

- After extensive deliberation, the stakeholder group recommended that the County continue the current practice of assessing TSDCs for multifamily residential based on the type of unit only (without consideration of the size of the unit). The County's existing ordinance has a number of potential discounts that are available to multifamily development projects.

Attachment D: Portland Metro Home Builders Association Testimony

Home Builders Association
of Metropolitan Portland

October 30, 2019

Jim Bernard, Chair
Clackamas County Commissioners
2051 Kaen Road
Oregon City, OR 97045

Subject: Clackamas County Residential Transportation System Development Charge

Dear Chair Bernard and Commissioners,

The Home Builders Association of Metropolitan Portland (HBA) represents over 1,400 companies and tens of thousands of women and men who work in the residential building and remodeling industries throughout the greater Portland area. We work to promote housing affordability and are dedicated to maximizing housing choice for all who reside in the region.

The HBA recognizes and supports system development charges based on the proper identification of infrastructure needs to accommodate new housing coupled with appropriate funding strategies. We commend the Clackamas County Board of Commissioners and staff who have continued to engage with the residential development community on proposed updates to the Transportation System Development Charge (TSDC) methodology and rules. In a time of continued population growth and rising home production costs, policy-makers and builders must work together to achieve true housing affordability.

The proposed 2019 TSDC update represents a logical progression from the 2016-2018 TSDC update process. The current proposal shifts away from relying on an average daily trip rate and a flat charge for all single family residential, to relying on data that links household-generated trips to home square footage. While this applied methodology increases the TSDC for homes 3,000 square feet or greater, it reduces the TSDC for homes under 1,700 square feet, and does not increase the charge for homes between 1,700 and 2,999 square feet. Notably, by lowering the TSDC by 12.5% for homes under 1,700 square feet, the County paves the way for smaller, relatively more affordable housing to accommodate the growing demand for housing at a variety of income levels.

As part of the TSDC analysis, county staff selected local data over national data in an effort to align the proposed methodology with land use trends and household trip behavior in the state and region. The HBA supports the use of this local data – instead of national data – as we believe it provides the most appropriate linkage between current trip and home size data. We look forward to continuing our strong partnership with Clackamas County as we collectively advance opportunities for new needed housing.

Sincerely,

Roseann Johnson
Assistant Director of Government Affairs

Elizabeth Comfort
Finance Director, Interim

Department of Finance
Public Services Building
2051 Kaen Road, Suite 490 | Oregon City, OR 97045

April 16, 2020

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of an Order Authorizing Financings for New Projects and Refinancing

Purpose/Outcomes	To authorize the issuance of debt that will refinance existing debt to a better interest rate and issue new debt to fund three current projects: the Road Maintenance Facility, the OSU Extension facility, and the Oak Grove and Gladstone Libraries.
Dollar Amount and Fiscal Impact	Issuance of up to $35.7 million in new debt and refinance up to ~$54.8 million in existing debt
Funding Source	Road Fund for Road Maintenance Facility, contributions from the Extension and 4-H Service District for the OSU Extension Facility, and the General Fund for the Oak Grove and Gladstone Libraries, with possible subsequent support from distributions from the Library District of Clackamas County.
Duration	Debt is anticipated to be issued for a 20 year term.
Previous Board Action/Review	Prior discussions related to budget and financing strategies
Strategic Plan Alignment	1. Build Public Trust Through Good Government: The issuance of the refinancing should result in cost savings through lower interest rates. 2. Build Strong Infrastructure: Construction of three facilities to meet prior commitments made to the citizens of Clackamas County
Contact Persons	Elizabeth Comfort, Interim Finance Director (503 504 0963) Chris Storey, WES Assistant Director (503 742 4543)

Clackamas County Finance is responsible for managing the County's debt portfolio. The County currently is rated AAA by Moody's rating agency, their highest rating, reflecting the overall financial health of Clackamas County as an organization. That high rating may enable the County to refinance existing obligations to result in savings on interest, and borrow at the lowest available cost for new projects. The attached order authorizes the issuance of debt to accomplish both of these purposes under what is being labeled the "2020 Omnibus Issuance."

BACKGROUND:

The County issued Full Faith and Credit Obligations, Series 2009 in the principal amount of $34,795,000 to finance several projects, including the remodeling of Sunnybrook Service Center to create the Brooks Building as Clackamas County Sheriff's Office headquarters, remodeling and improving the Clackamas County Jail, providing an evidence processing facility on behalf of the Sheriff and District Attorney, and completing the Development Services Building.

The County also entered into a Full Faith and Credit Financing Agreement dated September 14, 2012 in the principal amount of $20,080,000 to finance a portion of the Portland-Milwaukie Light Rail project. Collectively, the 2009 and 2012 Issuances' currently outstanding principal represent ~$57 million in existing debt currently being paid by the general fund. It is hoped that interest rates at the time of issuance will be lower than those in 2009 and 2012, and savings will result for the County. If interest rates will not result in material savings, this portion of the issuance will not be undertaken.

Further, several new capital needs are at a critical point at this time. Each could be funded via a separate issuance, but each issuance results in a transaction cost, often on the order of $200,000 per issuance. To save money, County Finance is proposing to combine the issuance of debt not only for refinancing the existing debt, but also for three separate projects, resulting in the single 2020 Omnibus Issuance. This should result in materials savings on both transaction costs and interest rates for component funds or elements that can utilize the County's superior AAA rating.

The first and largest project is for the Department of Transportation and Development ("DTD"). DTD's current Road Maintenance Facility is in need of substantial investment for continued functioning, yet lies in a flood plain and was inundated in 1996. The Board has agreed to relocate the facility out of the floodplain at a higher elevation in Oregon City, and a contract was executed to that effect. Construction of the new facility is underway. Approximately $20 million is necessary to meet the requirements of that contract. The debt service associated with this portion of the borrowing will be supported by the Road Fund.

The County, per its intergovernmental agreement with the State of Oregon through Oregon State University, is required to provide a facility for the OSU Extension Program. In return, the State provides the staff, including several professors. The current Extension office is slated for eventual demolition to support the County Courthouse and related improvements on the Red Soils Campus, and is inadequate to house the desired Extension program. A new facility has been designed and will be constructed at the corner of Warner Milne and Beavercreek in Oregon City, still within the Red Soils campus but at a different location. The Clackamas County Extension and 4-H Service District (the "Extension District"), a county service district governed by the Board, provides the County-required annual support for the Extension Service in lieu of General Fund contributions. The Extension District has been building capital reserves since its' inception in 2009, and currently has ~$8 million available to contribute towards the cost of a new County facility for the Extension program. The remaining $6 million estimated to complete the project will be part of this issuance, and the debt service would be paid by revenues from the Extension District.

The third project relates to the construction of the Oak Lodge and Gladstone combined libraries. Pursuant to an intergovernmental agreement between Clackamas County and the City of Gladstone, both the city and County are contributing land and capital funds to support construction of a jointly operated library operation. The required capital contribution to complete the designed project is an estimated $8 million. This amount would be supported by the General Fund and represent new debt for that revenue source. The overall operational plan and use of Library funds have not been settled for the Oak Grove and Gladstone Libraries. It is possible that the debt service associated with this portion of the 2020 Omnibus Obligations could be supported in whole or part from distributions from the Library District of Clackamas County or other funds allocated to the operation of that portion of the library system.

This Order also preserves the ability of funds that are borrowed, if not needed for the three above projects, to be used on two known capital needs of the County, namely expenses relating to the relocation of divisions and programs due to the construction of a new County Courthouse, and upgrades in financial and other software anticipated to modernize County financial management systems. Again, funds will only be expended on these projects if not needed to complete the primary three projects listed above.

This proposed order has been reviewed and approved by County Counsel and outside Bond counsel.

RECOMMENDATION:

Staff respectfully recommends that the Board, as the governing body of Clackamas County, adopt the Order as presented.

Respectfully submitted,

Elizabeth Comfort, Director
County Finance

Attachment: Proposed Order

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

In the Matter of the Board of County Commissioners, Clackamas County, Oregon, Authorizing Financings for New Projects and Refundings.

ORDER NO. _____

WHEREAS, the County is authorized by ORS Section 271.390 to enter into financing agreements to finance or refinance real or personal property which the Board of County Commissioners determines is needed, and to authorize certificates of participation in the right to receive the payments due from the County under those financing agreements; and

WHEREAS, the County is authorized by ORS 287A.105 to incur bonded indebtedness within the meaning of Section 10, Article XI of the Oregon Constitution; and

WHEREAS, the estimated weighted average life of a financing agreement shall not exceed the estimated dollar weighted average life of the real or personal property to be financed or refinanced by such financing agreement; and

WHEREAS, the County issued Full Faith and Credit Obligations, Series 2009 in the principal amount of $34,795,000 (the "Series 2009 Obligations") to finance the following projects (collectively, the "2009 Projects"):

-- remodeling and improving the Sunnybrook Service Center, including creating a Clackamas County Sheriff's Office headquarters, updating systems in the building and remodeling the building;

-- remodeling and improving the Clackamas County Jail, including replacing the central control complex, modernizing lighting, redesigning interior space, creating courtroom space and offices, relocating visitation space, creating a video visitation unit, adding beds, and creating a secure medical unit;

-- providing an evidence processing facility, including compact mobile shelving, modern air handling equipment, offices and space for analysis of evidence;

-- completing the Development Services Building; and

WHEREAS, the County entered into the Full Faith and Credit Financing Agreement (Portland-Milwaukie Light Rail Project) dated September 14, 2012 in the principal amount of $20,080,000 (the "Series 2012 Obligation" and together with the Series 2009 Obligations, the "Refundable Obligations"), to finance a portion of the Portland-Milwaukie Light Rail project (the "2012 Project" and together with the 2009 Projects, the "Refundable Projects"); and

WHEREAS, the County is authorized to refinance the outstanding Refundable Obligations and may be able to reduce its debt service costs and/or favorably restructure its debt by refunding the Refundable Obligations; and

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

In the Matter of the Board of County Commissioners, Clackamas County, Oregon, Authorizing Financings for New Projects and Refundings.

ORDER NO. _____

WHEREAS, the County desires to obtain financing in a maximum principal amount of not more than $35,700,000 to provide the following projects (collectively, the "New Money Projects") including equipment and furnishings:

-- two library facilities and related infrastructure and improvements in the Oak Lodge and Gladstone service areas;

-- a facility and related infrastructure and improvements primarily for the Clackamas County Extension and 4-H District;

-- a County road maintenance and repair facility and related infrastructure and improvements;

-- relocation of existing facilities to new facilities and related infrastructure and improvements arising from or related to the construction of a new County Courthouse; and

-- software and hardware upgrades to existing County financial and technological systems; and

WHEREAS, the County may make expenditures on the New Money Projects (the "Expenditures") before the County borrows to finance the New Money Projects, and the rules of the United States Internal Revenue Service require the County to declare its official intent to reimburse itself for amounts that the County will spend before it borrows, in order for the County to reimburse itself for those Expenditures from the proceeds of a tax-exempt borrowing;

NOW THEREFORE, IT IS HEREBY ORDERED that the Board determines that the Refundable Projects were needed at the time they were financed and remain needed, and that it is desirable to refinance the Refundable Projects.

IT IS FURTHER ORDERED that the County may refinance all or a portion of the outstanding Refundable Obligations under the authority of ORS 271.390, ORS 287A.105, ORS 287A.360 through 287A.375 and the other applicable provisions of ORS Chapter 287A. The refunding obligations authorized by this section (the "Refunding Borrowings") may be issued in an amount sufficient to pay and redeem the Refundable Obligations to be refunded, plus an amount sufficient to pay estimated costs related to accomplishing the refunding and the issuing the Refunding Borrowings.

IT IS FURTHER ORDERED that the Board determines that the New Money Projects are needed, and that it is desirable to finance the New Money Projects.

IT IS FURTHER ORDERED that the County may obtain financing in a maximum principal amount of not more than $35,700,000 (the "Project Borrowings") to provide the New Money Projects and pay the estimated costs of the Project Borrowings under the authority of ORS 271.390, ORS 287A.105 and the other applicable provisions or ORS Chapter 287A.

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

In the Matter of the Board of County Commissioners, Clackamas County, Oregon, Authorizing Financings for New Projects and Refundings.

ORDER NO. _____

IT IS FURTHER ORDERED that the County hereby declares its official intent pursuant to Section 1.150-2 of the Treasury Regulations to reimburse itself with the proceeds of the Project Borrowings for any Expenditures paid before the Project Borrowings are issued.

IT IS FURTHER ORDERED that the Interim County Finance Director, or the County Administrator, or the Administrator's designee (each a "County Official") are hereby authorized, on behalf of the County and without further action by the Board, to:

1. Select all or a portion of the outstanding Refundable Obligations to be refunded.
2. Enter into one or more Refunding Borrowings and Project Borrowings (collectively, the "2020 Borrowings") for the purposes described in this Order and enter into one or more escrow agreements that authorize the escrow agent to issue obligations (the "Obligations") that are payable from payments the County makes under the 2020 Borrowings. The 2020 Borrowings shall constitute bonded indebtedness and be subject to the limits of ORS 287A.105. The obligation of the County to make financing payments under the 2020 Borrowings shall be unconditional. Pursuant to ORS 287A.315, the County Official may pledge the County's full faith and credit and taxing power within the limitations of Sections 11 and 11b of Article XI of the Oregon Constitution, and may agree to pay the 2020 Borrowings from any and all of the County's legally available funds, including granting liens on specific revenue sources. Subject to the limitations of this Order, the 2020 Borrowings may be in such form and contain such terms as the County Official may approve, including covenants for the benefit of the lenders or credit enhancement providers.
3. Determine whether the interest payable on each 2020 Borrowing will be includable in gross income or excludable from gross income under the Internal Revenue Code of 1986, as amended (the "Code").
4. Covenant for the benefit of the owners of tax-exempt obligations to comply with all provisions of the Code which are required for the interest component of financing payments payable under the related 2020 Borrowings to be excluded from gross income for federal income tax purposes.
5. Deem final and authorize the distribution of a preliminary official statement for each series of Obligations, authorize the preparation and distribution of a final official statement or other disclosure document for each series of Obligations, and enter into agreements to provide continuing disclosure for owners of each series of Obligations.
6. Apply for and purchase ratings, municipal bond insurance, or other forms of credit enhancements for the 2020 Borrowings and the Obligations, and enter into related agreements, as necessary.

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

In the Matter of the Board of County Commissioners, Clackamas County, Oregon, Authorizing Financings for New Projects and Refundings.

ORDER NO. _____

7. Enter into additional covenants for the benefit of the purchasers of the 2020 Borrowings and the Obligations which the County Official determines are desirable to sell the 2020 Borrowings and the Obligations on favorable terms.
8. Engage the services of verification agents, escrow agents, paying agents and any other professionals whose services are desirable to accomplish the financings and refinancings.
9. Enter into one or more escrow deposit agreements for the refunding and take actions to call, defease and redeem all or any portion of the outstanding Refundable Obligations.
10. Contribute legally available funds of the County towards the refunding.
11. Negotiate and enter into agreements with various County and external entities to further secure the 2020 Borrowings and Obligations or comply with covenants related to the use of proceeds and projects financed and refinanced.
12. Subject to the limitations of this Order, determine the final principal amount of each 2020 Borrowing, the interest rate or rates which each 2020 Borrowing and each series of Obligations shall bear, and the County's prepayment rights and other terms of each 2020 Borrowing and each series of Obligations.
13. Solicit competitive bids for the purchase of each series of the Obligations and award their sale to the bidder offering the most favorable terms to the County, select one or more underwriters, negotiate the terms of the sale of each series of Obligations, and sell that series to those underwriters; or select one or more commercial banks or other lenders, negotiate the terms of the sale of each 2020 Borrowing and sell each 2020 Borrowing to those commercial banks or lenders.
14. Execute and deliver any other certificates or documents and take any other actions which the County Official determines are desirable to accomplish the financing and refinancing with the 2020 Borrowings and the Obligations in accordance with this Order.

DATED this 16th day of April, 2020.

CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS

_____
Chair

_____
Recording Secretary

DRAFT

Approval of Previous Business Meeting Minutes:

March 12, 2020

BOARD OF COUNTY COMMISSIONERS BUSINESS MEETING MINUTES

A complete video copy and packet including staff reports of this meeting can be viewed at https://www.clackamas.us/meetings/bcc/business

Thursday, March 12, 2020 – 10:00 AM
Public Services Building
2051 Kaen Rd., Oregon City, OR 97045

PRESENT: **Chair Jim Bernard**
Commissioner Sonya Fischer
Commissioner Ken Humberston
Commissioner Paul Savas (arrived during the 2nd public hearing II.2)
Commissioner Martha Schrader

CALL TO ORDER

- Roll Call
- Pledge of Allegiance

I. CITIZEN COMMUNICATION

https://www.clackamas.us/meetings/bcc/business

1. Les Poole, Clackamas County – he brought a small tree (oxygen machine) – he will be attending a meeting at Metro today.

*SPECIAL BOARD ACTION ITEM

1. Approval of **Resolution No. 2020-14** Amending & Extending Board Order No. 2020-09 Declaring a Local State of Emergency and Declaring Emergency Measures

Nancy Bush, Disaster Management spoke about the Order declaring a local state of emergency and declaring emergency measures. The original order expires and this new order/resolution will extend the time of this declaration until June 30, 2020. This declaration can be amended as needed.

https://www.clackamas.us/meetings/bcc/business

~Board Discussion~

Dr. Sarah Present, Public Health Officer – gave an update regarding "social distancing" measures.

~Board Discussion~

Rich Swift, Health, Housing & Human Services gave an updates from H3S.

MOTION:

Commissioner Humberston:	I move we approve the Resolution amending and extending board order No. 2020-09, declaring a local state of emergency and declaring emergency measures.
Commissioner Schrader:	Second.
~Discussion~	
all in favor.	
Commissioner Humberston:	Aye.
Commissioner Fischer:	Aye.
Commissioner Schrader:	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion carries 4-0.

II. PUBLIC HEARINGS

1. **Board Order No. 2020-15** Regarding the Proposed Withdrawal of County Road Status from a Portion of Otty Street (98th Ave.), County Road No. 2447

Doug Cutshall, Department of Transportation & Development presented the staff report.

Chair Bernard opened the public hearing and asked if anyone would like to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston:	I move we approve the Board Order regarding the proposed withdrawal of County Road Status from a Portion of Otty Street (98th Ave.), County Road No. 2447.Resolution amending and extending board order No. 2020-09, declaring a local state of emergency and declaring emergency measures.
Commissioner Schrader:	Second.
~Discussion~	
all in favor..	
Commissioner Humberston:	Aye.
Commissioner Fischer:	Aye.
Commissioner Schrader:	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion carries 4-0.

2. First Reading of **Ordinance No. 03-2020** Amending the Clackamas County Code Chapter 8.02, Transient Room Tax

Haley Fish, Finance Department, Andrew Naylor, County Counsel presented the staff report.
Chair Bernard opened the public hearing and asked if anyone would like to speak.
https://www.clackamas.us/meetings/bcc/business

1. Les Poole, Gladstone – needs more outreach for these type of items – opposed to the process.

Chair Bernard asked if anyone else would like to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston:	I move we read the Ordinance by title only.
Commissioner Fischer:	Second.
all those in favor/opposed/abstain:	
Commissioner Fischer:	Aye.
Commissioner Humberston:	Aye.
Commissioner Savas:	Abstain.
Commissioner Schrader:	Abstain.
Chair Bernard:	Aye – the Ayes have it, the motion carries 3-0-2.

Chair Bernard asked the Clerk to read the Ordinance by title only.
The Clerk assigned **Ordinance No. 03-2020** and read the ordinance by title only.
Chair Bernard announced the second reading will be on Thursday, March 26, 2020 at our regular scheduled Business meeting at 10 AM.

III. CONSENT AGENDA

Chair Bernard asked the Clerk to read the consent agenda by title only, then asked for a motion.

MOTION:

Commissioner Schrader:	I move we approve the consent agenda.
Commissioner Humberston:	Second.
all those in favor/opposed:	
Commissioner Humberston:	Aye.
Commissioner Fischer:	Aye.
Commissioner Savas:	Aye.
Commissioner Schrader:	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion carries 5-0.

A. Health, Housing & Human Services

1. Approval of Intergovernmental Agreement with Tri-County Metropolitan District of Oregon for Special Transportation Formula Funds for the Mt Hood Express Bus Service, Dedicated Dialysis Rides Program and Match Funds for Title XIX (Medicaid) Non-Medical Wavered Transportation – *Social Services*

2. Approval to Purchase a Total of Two Buses: One Category E Transit Bus from Creative Bus Sales and One Category D Bus from Creative Bus Sales for Use by Transportation Reaching People and the Mt Hood Express Service – *Procurement*

B. Department of Transportation & Development

1. Approval of a 2020 Fund Exchange Agreement with Oregon Department of Transportation for the South Upper Highland Road Project

C. Elected Officials

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

D. County Counsel

1. **Board Order No. 2020-16** for Formal Approval of the Comprehensive Plan Amendment, Zone Map Amendment and Site Plan Review Request for a Mining Operation Located on the West Side of South Barlow Road, South of the Intersection of South Barlow Road and South Highway 99E (*approved at the 2-5-2020 Land Use Hearing*)

E. Community Corrections

1. Approval of Blanket Purchase Agreement between Clackamas County Community Corrections and Dept. of Veteran Affairs, National Cemetery Administration to Provide Work Crew Services

IV. CLACKAMAS COUNTY EXTENSION & 4-H SERVICE DISTRICT

1. Approval of an Easement at the North Willamette Research and Extension Center Providing Portland General Electric Access to Install Electric Service for a New Irrigation Well

V. COUNTY ADMINISTRATOR UPDATE
https://www.clackamas.us/meetings/bcc/business

VI. COMMISSIONERS COMMUNICATION
https://www.clackamas.us/meetings/bcc/business

MEETING ADJOURNED 10:56 AM

NOTE: ***Regularly scheduled Business Meetings are televised and broadcast on the Clackamas County Government Channel. These programs are also accessible through the County's Internet site. DVD copies of regularly scheduled BCC Thursday Business Meetings are available for checkout at the Clackamas County Library in Oak Grove. You may also order copies from any library in Clackamas County or the Clackamas County Government Channel.*** https://www.clackamas.us/meetings/bcc/business

Evelyn Minor-Lawrence
Director

DEPARTMENT OF HUMAN RESOURCES

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

April 16, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of 2020 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 2020 and five Summary Plan Descriptions for the 2020 plan year.
Dollar Amount and Fiscal Impact	The estimated fiscal impact for the 2020 plan year is: $39,456,716.40
Funding Source	Department, employee, and retiree contributions
Duration	Effective January 1, 2020 – December 31, 2020
Previous Board Action	This agreement received Board of County Commissioner's preliminary approval at the Board of County Commissioner's Policy Session on December 3, 2019.
County Counsel Review	This Administrative Services Agreement and the five summary plan descriptions have been reviewed and approved by County Counsel on April 1, 2020.
Strategic Plan Alignment	Builds public trust through good government.
Contact Person	Kristi Durham, Human Resources, 503.742.5470

BACKGROUND:
At the Policy Session on December 3, 2019, the Board of County Commissioners approved the 2020 benefit plan renewals. The Providence plan Administrative Services Agreement and the Summary Plan Descriptions require the board's approval and signature.

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

RECOMMENDATION:
Staff recommends the Board approve the 2020 Administrative Services Agreement and Summary Plan Descriptions from Providence Health Plan.

Sincerely,

Kristi Durham, Benefits Manager
Department of Human Resources

CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES

PERSONAL OPTION PLAN
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

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

Clackamas County Employee Services: 503-655-8459

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.Providence Health Plan
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us" or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
- Our Providence Signature Network of 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 http://phppd.providence.org/. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- Certain Covered Services require an approved Prior Authorization, as specified in section 3.7.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in Plan documents. You should read the provisions, limitation and exclusions before seeking Covered Services because not all health care services are covered by this Plan.
- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

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

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

Your Plan allows you to receive Covered Services from 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 http://phppd.providence.org/, 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 http://phppd.providence.org/. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need 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. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.

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 http://phppd.providence.org/. 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 his or her office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

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

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

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

3.2.4 Changing Your Primary Care Provider

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

3.2.5 Office Visits

Primary Care Providers

We recommend you see your Primary Care Provider for all routine care and call your Primary Care Provider first for urgent or specialty care. If you need medical care when your Primary Care Provider is not available, the physician/provider on call may treat you and/or recommend that you see another provider 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 http://phppd.providence.org/, 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 *unless* we have Prior Authorized the Out-of-Network Provider/Facility and the Services received.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If the approved, Prior Authorized Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

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

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

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

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

	Provider's Status	
Item	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.
- 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/womensguidelines.

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

4.1.1 Physical Examinations and Well-Baby Care

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

Recommended Guidelines:

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

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

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

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.14.

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.

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. He or she may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

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

4.3.8 Retail Health Clinics

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- 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 or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to 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 or their authorizing agent.

4.5.5 Urgent Care

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

Whenever you need urgent care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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, lancets and test strips, may be purchased through Providence Health Plan medical supply providers or under this benefit at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

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

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in 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 3.7.

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

4.10.2 Applied Behavior Analysis

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

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us or our authorizing agent;

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

Exclusions to ABA Services:

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

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, 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. 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 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

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 glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.7.4.
- Self-administered chemotherapy drugs are covered under section 4.8.14 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.1.4.

- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances and Deductibles.

4.14.2 Use of Out-of-Network Pharmacies

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

To request reimbursement, you will need to fill out and submit to 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.

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.

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 hyperactivity 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 placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (*e.g.,* gloves, shampoo);

18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as “less than effective” by the FDA (also known as “DESI” drugs); and
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.

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;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (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;
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of 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;
- 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 <u>Vision Services</u>:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism; and
- 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 <u>Hearing Services</u>:

- 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

6.1.2 Right of Recovery

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

6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

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

Allowable expense

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

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

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

Closed panel plan

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

Custodial parent

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

6.2.2 Order of Benefit Determination Rules

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    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;
- Imposition of a pre-existing condition exclusion, source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

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

Authorized Representative

An individual who by law or by the 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, upon request and free of charge, have reasonable access to and copies of the documents and records, and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of Appeal.

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

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

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

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling 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 us with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made over the phone by calling Customer Service or by contacting Clackamas County Employee Services.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Employee Services.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

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

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

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

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

3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New Dependents

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

The "special enrollment period" shall be a period of 60 days and begins on the later of:

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

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

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

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3

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

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

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

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

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

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

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

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

10. CONTINUATION OF GROUP MEDICAL BENEFITS

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

10.1 COBRA CONTINUATION COVERAGE

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

10.1.1 Subscriber's Continuation Coverage

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

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

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

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

10.1.3 Dependent's Continuation Coverage

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

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

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

10.1.4 Notice Requirements

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

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

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 COBRA Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay 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 his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

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

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

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

36-Month Continuation Period

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

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

10.1.9 Extension of Continuation Period

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

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

10.1.10 Trade Act of 2002

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

10.1.11 When COBRA Continuation Coverage Ends

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

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

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and 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
Risk & Benefit Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

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

14.7.1 Complete Allocation of Fiduciary Responsibilities

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

14.8 ENGAGEMENT OF ADVISORS

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

14.9 INDEMNIFICATION

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

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

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

14.10.2 Manner of Action

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

14.10.3 Effect on Benefits

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

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

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

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

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

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

14.11.2 Security

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

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

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

Adverse Benefit Determination
See section 7.

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

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other 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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee

Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Personal Option General County Employees, COBRA-participants and Non Medicare Eligible Early Retirees.
3. Work Hours: Regularly scheduled for at least 20 hours per week (18.75 hours per week for Job Share). Not applicable to COBRA and Early Retiree.
4. Eligibility Waiting Period: Two months. A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff.
5. Effective Date of Coverage: First of the month following completion of the Eligibility Waiting Period. COBRA – first day following loss of Active coverage. Early Retiree – first of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA and/or Portability provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

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 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 review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.7.

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

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

Providence Health Plan

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

Qualified Practitioner
Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, naturopath, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery
Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or corrects a congenital deformity or anomaly that results in a functional impairment.

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

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

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

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

Subscriber
Subscriber means an employee or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

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

Termination Date of Coverage

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

Urgent Care

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

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

Usual, Customary and Reasonable (UCR)

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

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

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

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

Virtual Visit

Virtual Visit means a visit with an In-Network Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

Women's Health Care Provider

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

16. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at:

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

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

Language Access Information

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (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'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, 2020.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by:

Customer Service: 503-574-7500 or 800-878-4445
Sales: 503-574-6300 or 877-245-4077
www.ProvidenceHealthPlan.com

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

CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES

OPEN OPTION PLAN
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

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

Clackamas County Employee Services: 503-655-8459

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.Providence HealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us," or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
    - Our Providence Signature Network of 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:
    - Virtual 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 http://phppd.providence.org/. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations, and exclusions that are specified in Plan documents. You should read the provisions, limitation, and exclusions before seeking Covered Services because not all health care services are covered by this Plan.

- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

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

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN

Your Plan allows you to receive Covered Services from 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 http://phppd.providence.org/, 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 http://phppd.providence.org/. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need 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. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.

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 http://phppd.providence.org/. 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 his or her office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

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

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

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

3.2.4 Changing Your Primary Care Provider

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

3.2.5 Office Visits

Primary Care Providers

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

- Virtual 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.

- 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/womensguidelines.

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

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination, and as indicated in section 4.1.9. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

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

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

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

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.14.

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.

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 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. He or she may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

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

4.3.8 Retail Health Clinics

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- 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.

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 or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to 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 or their authorizing agent.

4.5.5 Urgent Care

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

Whenever you need urgent care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. (See section 8.2.4 regarding newborn eligibility and enrollment.)

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

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

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, lancets and test strips, may be purchased through Providence Health Plan Network medical supply providers or under this benefit at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

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

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in 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 or our authorizing agent;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

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

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, 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. 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 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-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 glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.7.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances, and Deductibles.

4.14.2 Use of Out-of-Network Pharmacies

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

To request reimbursement, you will need to fill out and submit to 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.

4.14.4 Prescription Drugs

<u>Generic and Brand-Name Prescription Drugs</u>

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.

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 hyperactivity 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 placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. Drug kits unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (*e.g.,* gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.

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;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (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;
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of 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;
- 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 <u>Vision Services</u>:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism; and
- 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 <u>Hearing Services</u>:

- 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

6.1.2 Right of Recovery

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

6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

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

Allowable expense

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

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

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

Closed panel plan

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

Custodial parent

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

6.2.2 Order of Benefit Determination Rules

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    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;
- Imposition of a pre-existing condition exclusion, source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

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

Authorized Representative

An individual who by law or by the 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, upon request and free of charge, have reasonable access to and copies of the documents and records, and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of Appeal.

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

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

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

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling 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 us with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Employee Services.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Employee Services.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

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

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

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

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and

b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and

c) Such coverage:
    - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
    - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
        1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
        2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or

3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New Dependents

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

The "special enrollment period" shall be a period of 60 days and begins on the later of:

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

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

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

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

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

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

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

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

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

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

10. CONTINUATION OF GROUP MEDICAL BENEFITS

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

10.1 COBRA CONTINUATION COVERAGE

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

10.1.1 Subscriber's Continuation Coverage

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

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

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

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

10.1.3 Dependent's Continuation Coverage

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

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

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

10.1.4 Notice Requirements

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

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

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 COBRA Premiums

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

10.1.8 Length of COBRA Continuation Coverage

<u>18-Month Continuation Period</u>

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

29-Month Continuation Period

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

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

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

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

36-Month Continuation Period

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

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

10.1.9 Extension of Continuation Period

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

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

10.1.10 Trade Act of 2002

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

10.1.11 When COBRA Continuation Coverage Ends

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

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

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and 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
Risk & Benefit Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

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

14.7.1 COMPLETE ALLOCATION OF FIDUCIARY RESPONSIBILITIES

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

14.8 ENGAGEMENT OF ADVISORS

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

14.9 INDEMNIFICATION

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

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

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

14.10.2 Manner of Action

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

14.10.3 Effect on Benefits

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

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

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

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) The Employer shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.

(i) The Employer shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
(j) The Employer shall provide for adequate separation between the Employer and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of the Employer:
(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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee

Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Open Option General County Employees, COBRA participants, Non-Medicare Eligible Early Retirees, and Job Share.
3. Work Hours: Regularly scheduled for at least 20 hours per week (18.75 hours for Job Share). Not applicable to COBRA participants and Non-Medicare Eligible Early Retirees.
4. Eligibility Waiting Period: Two months. A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff.
5. Effective Date of Coverage: First of the month following completion of the Eligibility Waiting Period COBRA – first day following loss of Active coverage. Early Retiree – first of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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

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 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 an In-Network Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

Women's Health Care Provider

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

16. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at:

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

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

Language Access Information

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (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'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, 2020.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by:

Customer Service: 503-574-7500 or 800-878-4445
Sales: 503-574-6300 or 877-245-4077
www.ProvidenceHealthPlan.com

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

CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION PERSONAL OPTION GRANDFATHERED PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

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

Clackamas County Employee Services: 503-655-8459

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.Providence HealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION 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 http://phppd.providence.org/. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- Certain Covered Services require an approved Prior Authorization, as specified in section 3.7.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 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 http://phppd.providence.org/, 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 http://phppd.providence.org/. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

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

2.3 CUSTOMER SERVICE

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

- Specific benefit or claim questions.
- Questions or concerns about your health care or service.

Contacting Providence Customer Service

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

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

You may **access claims and benefit information 24 hours a day, seven days a week** 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. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.

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 http://phppd.providence.org/. 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 his or her office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

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

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

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

3.2.4 Changing Your Primary Care Provider

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

3.2.5 Office Visits

Primary Care Providers

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

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. He or she may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

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

4.3.8 Retail Health Clinic

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- 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 or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to 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 or their authorizing agent.

4.5.5 Urgent Care

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

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

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). 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.

Covered Services include:

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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

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

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

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES 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, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices.

3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

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

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in 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 or our authorizing agent;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

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

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, 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. 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 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 glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

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

To request reimbursement, you will need to fill out and submit to 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.

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 hyperactivity 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 placed on a prescription-only status as required by state or local law;
13. Replacement of lost or stolen medication;
14. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
15. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
16. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g. gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs used for weight loss or for cosmetic purposes;
20. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and
21. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.

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 http://phppd.providence.org/ or call Customer Service.

You do not need a physician's referral to see a chiropractor.

In rare circumstances, our national network may not include a Network chiropractor in your area. If this happens, please contact Customer Service before making an appointment. If Customer Service is unable to locate 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;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (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;
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

6.1.2 Right of Recovery

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

6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

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

Allowable expense

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

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

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

Closed panel plan

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

Custodial parent

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

6.2.2 Order of Benefit Determination Rules

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    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, upon request and free of charge, have reasonable access to and copies of the documents, records, and other information relevant to Providence Health Plan's decision, including the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of Appeal.

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

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

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

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

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

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact 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 us with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Employee Services.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Employee Services

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

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

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

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

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and

b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and

c) Such coverage:
    - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
    - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
        1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
        2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or

3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New Dependents

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

The "special enrollment period" shall be a period of 60 days and begins on the later of:

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

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

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

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

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

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

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

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

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

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

10. CONTINUATION OF GROUP MEDICAL BENEFITS

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

10.1 COBRA CONTINUATION COVERAGE

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

10.1.1 Subscriber's Continuation Coverage

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

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

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

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

10.1.3 Dependent's Continuation Coverage

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

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

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

10.1.4 Notice Requirements

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

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

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 COBRA Premiums

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

10.1.8 Length of COBRA Continuation Coverage

<u>18-Month Continuation Period</u>

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

29-Month Continuation Period

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

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

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

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

36-Month Continuation Period

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

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

10.1.9 Extension of Continuation Period

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

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

10.1.10 Trade Act of 2002

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

10.1.11 When COBRA Continuation Coverage Ends

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

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

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and 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
Risk & Benefit Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of the County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

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

14.7.1 Complete Allocation of Fiduciary Responsibilities

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

14.8 ENGAGEMENT OF ADVISORS

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

14.9 INDEMNIFICATION

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

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

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

14.10.2 Manner of Action

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

14.10.3 Effect on Benefits

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

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

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

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) The Employer shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
(i) The Employer shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
(j) The Employer shall provide for adequate separation between the Employer and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of the Employer:
    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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee

Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Personal Option Peace Officer Association Employees, COBRA participants and Non-Medicare Eligible Early Retirees.
3. Work Hours: Peace Officers regularly scheduled for at least 20 hours per week. (Not applicable to COBRA and Non-Medicare Eligible Early Retiree.)
4. Eligibility Waiting Period: Two months. A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff.
5. Effective Date of Coverage: First of the month following completion of the Eligibility Waiting Period. COBRA – first day following loss of Active coverage. Early Retiree – first of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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

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 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, 2020.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by:

Customer Service: 503-574-7500 or 800-878-4445
Sales: 503-574-6300 or 877-245-4077
www.ProvidenceHealthPlan.com

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

CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION
OPEN OPTION GRANDFATHERED PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

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

Clackamas County Employee Services: 503-655-8459

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.Providence HealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION OPEN OPTION GRANDFATHERED PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us" or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
    - Our Providence Signature Network of 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:
    - Virtual 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 http://phppd.providence.org/. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 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 http://phppd.providence.org/, 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 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 http://phppd.providence.org/. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

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

2.3 CUSTOMER SERVICE

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

- Specific benefit or claim questions.
- Questions or concerns about your health care or service.

Contacting Providence Customer Service

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

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

You may **access claims and benefit information 24 hours a day, seven days a week** 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. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.

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 http://phppd.providence.org/. 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 his or her office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

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

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

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

3.2.4 Changing Your Primary Care Provider

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

3.2.5 Office Visits

Primary Care Providers

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

- Virtual 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.

- 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/womensguidelines.

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

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

4.3.8 Retail Health Clinic

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

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

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

<u>Definitions:</u>

"Emergency Medical Condition" is a medical condition 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.

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 or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to 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 or their authorizing agent.

4.5.5 Urgent Care

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

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

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). 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.

Covered Services include:

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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

Maternity support services: Members may attend a class to prepare for childbirth. The classes are held at 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, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices.

3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

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

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in 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 or our authorizing agent;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

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

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, 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. 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 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 glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

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

To request reimbursement, you will need to fill out and submit to 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.

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 hyperactivity 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 placed on a prescription-only status as required by state or local law;
13. Replacement of lost or stolen medication;
14. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
15. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;

16. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs used for weight loss or for cosmetic purposes;
20. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and
21. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.

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 http://phppd.providence.org/ or call Customer Service.

You do not need a physician's referral to see a chiropractor.

In rare circumstances, our national network may not include a Network chiropractor in your area. If this happens, please contact Customer Service before making an appointment. If Customer Service is unable to locate 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;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (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;
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

6.1.2 Right of Recovery

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

6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

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

Allowable expense

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

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

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

Closed panel plan

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

Custodial parent

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

6.2.2 Order of Benefit Determination Rules

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    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, upon request and free of charge, have reasonable access to and copies of the documents, records, and other information relevant to Providence Health Plan's decision, including the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of Appeal.

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

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

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

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

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

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact 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 us with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Employee Services

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Employee Services.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

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

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

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

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

3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New Dependents

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

The "special enrollment period" shall be a period of 60 days and begins on the later of:

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

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

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

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

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

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

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

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

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

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

10. CONTINUATION OF GROUP MEDICAL BENEFITS

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

10.1 COBRA CONTINUATION COVERAGE

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

10.1.1 Subscriber's Continuation Coverage

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

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

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

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

10.1.3 Dependent's Continuation Coverage

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

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

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

10.1.4 Notice Requirements

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

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

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 COBRA Premiums

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

10.1.8 Length of COBRA Continuation Coverage

<u>18-Month Continuation Period</u>

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

29-Month Continuation Period

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

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

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

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

36-Month Continuation Period

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

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

10.1.9 Extension of Continuation Period

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

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

10.1.10 Trade Act of 2002

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

10.1.11 When COBRA Continuation Coverage Ends

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

- Clackamas County no longer provides health coverage to any employees;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary (employee, spouse or dependent child) later becomes covered under another health plan;
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and 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
Risk & Benefit Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

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

14.7.1 Complete Allocation of Fiduciary Responsibilities

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

14.8 ENGAGEMENT OF ADVISORS

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

14.9 INDEMNIFICATION

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

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

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

14.10.2 Manner of Action

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

14.10.3 Effect on Benefits

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

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

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

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

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

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

14.11.2 Security

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

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

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

Adverse Benefit Determination
See section 7.

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other 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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee

Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Open Option Peace Officers Association Employees, COBRA-participants and non-Medicare eligible Early Retirees.
3. Work Hours: Peace Officers regularly scheduled for at least 20 hours per week. Not applicable to COBRA and Early Retiree.
4. Eligibility Waiting Period: Active -Two months. A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff.
5. Effective Date of Coverage: Active - First of the month following completion of the Eligibility Waiting Period. COBRA – first day following loss of Active coverage. Early Retiree – first of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.

8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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

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 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 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 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, 2020.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by:

Customer Service: 503-574-7500 or 800-878-4445
Sales: 503-574-6300 or 877-245-4077
www.ProvidenceHealthPlan.com

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

CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES
EARLY RETIREES – COBRA PARTICIPANTS – TEMPORARY EMPLOYEES

OPEN OPTION PLAN
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

1. INTRODUCTION

Statement from Plan Sponsor

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

Clackamas County Employee Services: 503-655-8459

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.Providence HealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com

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

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us," or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
    - Our Providence Signature Network of 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:
    - Virtual 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 http://phppd.providence.org/. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in Plan documents. You should read the provisions, limitation and exclusions before seeking Covered Services because not all health care services are covered by this Plan.

- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

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

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

Your Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan allows you to receive Covered Services from 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 http://phppd.providence.org/, 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 http://phppd.providence.org/. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need 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. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.

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 http://phppd.providence.org/. 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 his or her office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

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

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

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

3.2.4 Changing Your Primary Care Provider

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

3.2.5 Office Visits

Primary Care Providers

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

- Virtual 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.

- 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.

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 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/womensguidelines.

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

4.1.1 Physical Examinations and Well-Baby Care

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

Recommended Guidelines:

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

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

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

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

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.

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 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 Internet security technology approved by us to protect your information from unauthorized access or release.
- Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by 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. He or she may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

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

4.3.8 Retail Health Clinic

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

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

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

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.

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 or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to 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 or their authorizing agent.

4.5.5 Urgent Care

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

Whenever you need urgent care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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, lancets and test strips, may be purchased through Providence Health Plan Network medical supply providers or under this benefit at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

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

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in 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 or our authorizing agent;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

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

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, 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. 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 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-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 glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances and Deductibles.

4.14.2 Use of Out-of-Network Pharmacies

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

To request reimbursement, you will need to fill out and submit to 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.

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.

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 hyperactivity 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 placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (*e.g.,* gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.

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;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (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;
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of 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;
- 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 <u>Vision Services</u>:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- 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 <u>Hearing Services</u>:

- 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

6.1.2 Right of Recovery

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

6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

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

Allowable expense

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

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

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

Closed panel plan

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

Custodial parent

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

6.2.2 Order of Benefit Determination Rules

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    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;
- Imposition of a pre-existing condition exclusion, source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

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

Authorized Representative

An individual who by law or by the 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, upon request and free of charge, have reasonable access to and copies of the documents and records, and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of Appeal.

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

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

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

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling 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 us with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Employee Services

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Customer Service.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 days of the qualifying event and meet the applicable requirements stated in this section.

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

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 Loss of Other Coverage

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

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and

b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if the Plan required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and

c) Such coverage:
   - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
   - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
     1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
     2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or

3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New Dependents

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

The "special enrollment period" shall be a period of 60 days and begins on the later of:

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

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a Spouse or minor child under your Health Benefit Plan, the Plan will provide a "special enrollment period" for you and the Spouse or minor child you are ordered to provide coverage for if you request enrollment within 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 Premium Assistance

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

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

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

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

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

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

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

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

10. CONTINUATION OF GROUP MEDICAL BENEFITS

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

10.1 COBRA CONTINUATION COVERAGE

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

10.1.1 Subscriber's Continuation Coverage

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

10.1.2 Spouse's or Domestic Partner's Continuation Coverage

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

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

10.1.3 Dependent's Continuation Coverage

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

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

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

10.1.4 Notice Requirements

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

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

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 COBRA Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay 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 his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

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

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

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

36-Month Continuation Period

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

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

10.1.9 Extension of Continuation Period

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

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

10.1.10 Trade Act of 2002

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

10.1.11 When COBRA Continuation Coverage Ends

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

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

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan your physicians or providers need to provide care.

- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and 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
Risk & Benefit Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

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

14.7.1 Complete Allocation of Fiduciary Responsibilities

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

14.8 ENGAGEMENT OF ADVISORS

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

14.9 INDEMNIFICATION

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

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 Right to Amend or Terminate

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

14.10.2 Manner of Action

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

14.10.3 Effect on Benefits

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

14.11 PROTECTED HEALTH INFORMATION

14.11.1 Disclosure

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

(a) The Employer may use and disclose the PHI it receives only for the following purposes:
    1. Administration of the Plan; and
    2. Any use or disclosure as required by law.

(b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) The Employer shall not use or disclose the PHI obtained from Providence Health Plan for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

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

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

14.11.2 Security

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

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in section 14.11.1(j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

15. DEFINITIONS

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

Adverse Benefit Determination
See section 7.

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

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other 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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee
Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 8.1.
1. Employment Status: On-call, substitute, and seasonal employees are not eligible.
2. Employment Category/Class: Non-Medicare Early Retiree-COBRA-Temporary Employees.
3. Work Hours: Not applicable for Early Retirees or COBRA participants. Temporary Employees: work an average of 30 or more hours during the most recent Affordable Care Act measurement period or are hired with the intent of working more than an average of 30 hours per week for longer than 90 days.
4. Eligibility Waiting Period: Not applicable for Early Retirees or COBRA participants. Temporary Employees: minimum of 60 days.

5. Effective Date of Coverage: COBRA – first day following loss of Active coverage. Early Retiree – first of the month following retirement. Temporary Employees: the first day of the month following 60 days of employment working 30 or more hours per week or on January 1 if they met the definition of fulltime under the Affordable Care Act during the most recent measurement period.
6. Location: Not applicable for Early Retirees and COBRA participants.
7. Leave of Absence Status: Not applicable for Early Retirees and COBRA participants. Temporary Employees: An otherwise eligible Temporary Employee on an Employer-approved Leave of Absence shall remain eligible during the first 6 months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: Not applicable.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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

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 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 an In-Network Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

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

16. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

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

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

Language Access Information

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (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 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, 2020.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by:

Customer Service: 503-574-7500 or 800-878-4445
Sales: 503-574-6300 or 877-245-4077
www.ProvidenceHealthPlan.com

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

CLACKAMAS COUNTY

BUSINESS & COMMUNITY SERVICES
150 BEAVERCREEK ROAD
OREGON CITY, OR 97045
WWW.CLACKAMAS.US/BCS
LAURA ZENTNER, DIRECTOR

April 16, 2020

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Lease Agreement between Clackamas County and
River City Boat Sales, LLC to Lease, Manage and Operate the Boones Ferry Marina Facility

Purpose/Outcomes	Business & Community Services (BCS) - County Parks division has negotiated in good faith with River City Boat Sales, LLC for the lease of the commercial buildings and operations and management of the marina at the Boones Ferry Marina facility located along the Willamette River near Wilsonville. The lease agreement will provide a long term, sustainable revenue stream to County Parks.
Dollar Amount and Fiscal Impact	Approximately $199,000 in annual lease revenue to County Parks.
Funding Source	Fee Revenue from Lessee
Duration	Through April, 2025
Previous Board Action	Lease terms and conditions were presented to the Board of County Commissioners (BCC) in Executive Session on March 25, 2020.
Strategic Plan Alignment	1) This lease aligns with BCS goals to secure a sustainable source of revenue to help meet capital repair/replace funding requirements. 2) This lease further supports growing a vibrant economy with the Lessee being able to provide up to 15 family wage jobs at the Boones Ferry Marina facility.
County Counsel Review	County Counsel Review Date: March 24, 2020 Counsel Initials: ARN
Procurement Review	Was the item processed through procurement? Yes ☐ No ☒ This is a lease agreement.
Contact Person	Rick Gruen, BCS – County Parks Manager (503) 742-4345
Contract No.	N/A

BACKGROUND:
In April, 2019, BCS - County Parks division had the Boones Ferry Marina facility appraised by a qualified appraisal company to determine fair market value lease rates and assess the deferred maintenance and capital improvement requirements for the facility.

A Request for Information (RFI) was publicized to solicit proposals from parties interested in leasing the marina facility. Proposers were asked to outline how they would use the facility to maximize revenue potential if they were awarded a lease of the property. River City Boat Sales, LLC was identified as the top proposer. BCS – County Parks division has negotiated in good faith with River City Boat Sales, LLC to reach an Agreement in Principal, which was presented to the BCC in Executive Session on March 25, 2020. The lease includes provisions for a five year term with one additional five year renewal, fixed monthly payments on the commercial buildings, a revenue share arrangement for the seasonal operation of the marina, and a yearly capital contribution payment.

RECOMMENDATION:
Staff respectfully recommends Board approval of the Lease Agreement between Clackamas County and River City Boat Sales, LLC for the lease of the Boones Ferry Marina facility.

Attachments:

- Lease Agreement
- Exhibits A – D

Respectfully submitted,

Laura Zentner

Laura Zentner, CPA
Director, Business & Community Services

LEASE BETWEEN
BETWEEN CLACKAMAS COUNTY
AND RIVER CITY BOAT SALES, LLC

THIS LEASE ("Lease") is entered into by and between Clackamas County ("County"), a political subdivision of the State of Oregon, and River City Boat Sales, LLC ("Lessee"), collectively referred to as the "Parties" and each a "Party."

RECITALS

County owns certain real property described as follows:

Tax Lots 31W23DC02000, 900 and 800, more commonly known as Boones Ferry Marina, 26117/26177 Boones Ferry Landing, Aurora, OR 97002,

together with any and all rights, privileges, easements, and appurtenances (collectively, the "Premises"). The Premises includes any and all fixtures, rights, privileges, easements, and appurtenances (collectively the "Improvements") that may now or exist in the future.

The Premises is comprised of the following components:

1. A boat sales building and a services building (collectively the "Sales and Service Buildings"), totaling approximately 18,700 square feet, as detailed on Exhibit A-1, attached hereto and incorporated by this reference herein.
2. A public marina with associated docks, 98 boat slips and limited 15 stall parking area (hereinafter the "Marina"), totaling approximately 93,000 square feet, as detailed on Exhibit A-2, attached hereto and incorporated by this reference herein.
3. A public boat ramp, boarding dock and associated infrastructure (hereinafter the "Boat Ramp"), totaling approximately 10,200 square feet, as detailed on Exhibit A-3, attached hereto and incorporated by this reference herein.

County desires to lease to Lessee, and Lessee desires to lease from County, the Premises subject to the terms and conditions in this Lease.

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. **Lease of Premises; Condition of Premises**. County hereby leases the Premises to Lessee, subject to the terms and conditions contained herein. Lessee acknowledges that it has examined the Premises and agrees to accept the Premises in "as-is" condition, and that County has made no representations or warranties regarding the condition of the Premises or its fitness for any particular use.

2. **Term**. Upon execution of this Lease by both parties ("Effective Date"), the Premises will be leased for a term of five (5) years, with one optional renewal for an additional five (5) years upon written agreement by the Parties, unless earlier terminated pursuant to the terms of the Lease.

3. **Rental Payment**. Lessee shall make rent payments monthly on or before the 1st day of each month following the Effective Date of this Lease (the "Rental Payment"). Lessee shall have no right to offset rent due under this Lease. The amount of the Rental Payment shall be determined as follows:
    a. **First year**. For the first year of the Lease, Lessee agrees to pay County the annual sum of $124,730.00, to be paid in twelve equal monthly payments of $ 10,394.16. (Annual lease rate is calculated based on 18,700 square feet x 6.67/sq.ft).
    b. **Annual rental adjustment**. For each subsequent year of the Lease, the annual Rental Payment shall increase by the greater of either: (1) three percent (3%) over the prior year's annual rent; or (2) the percentage rate of change in the West Region (Size Class A) of the Consumer Price Index ("CPI") of the US Dept. of Labor, Bureau of Labor Statistics (the "Index") from the last month reported to the same month of the preceding year. Lessee shall pay the adjusted annual rent in twelve equal monthly payments.

       If the Index (or a successor or substitute index) is not available, a reliable governmental or other nonpartisan publication evaluating the information theretofore used in determining the Consumer Price Index shall be used in lieu of such Index.

4. **Annual Income Revenue Payment**.
    a. **Amount of Revenue Payment**. On November 1 of each year, Lessee agrees to pay the County the greater of either: (1) $60,000.00; or (2) thirty-five percent (35%) of the net income received from the operation of the Marina (the "Revenue Share Payment") received from April 1 through October 1 of each year. The Revenue Share Payment includes, but is not limited to, net income received from rental of boat slips, concession stand sales, fuel sales, kayak/canoe rentals, and similar transactions. As used herein, "net income" means the amount paid or payable for use of the Marina, including sales or services rendered by Lessee, either directly or indirectly from its licensees, invitees, agents, subleases, or otherwise, less the direct expenses incurred by Lessee in operating the Marina.

    b. **Annual audit**. Within ninety (90) days after the end of Lessee's fiscal year, but no later than December 31, Lessee will cause to be delivered to County a compiled financial statement prepared by an independent certified public accountant showing the results of operations including, but not limited to, all gross income received, expenses incurred, and any other data County determines is reasonably necessary to review and assess the Revenue Share Payment. The cost of such audit, if required, shall be borne by Lessee.

    c. **Annual tax return**. Lessee shall annually provide the County a copy of its annual tax return.

    d. **Periodic Review/Adjustment of Revenue Share**. County and Lessee shall agree to review and evaluate the revenue share formula following the completion of year #2 of the lease.

5. **Capital Contribution**. Lessee shall make monthly capital contribution payments ("Capital Contribution Payment") in the amount of $1,250.00 on or before the 1st day of each month following the Effective Date of this Lease. The Capital Contribution Payments are in consideration for capital improvements or repairs that County expects to perform over the Term of this Lease. Provided, however, that nothing herein shall be construed as a promise or commitment of County to perform a particular capital improvement or repair. Whether to make a capital improvement or repair shall be made by County, in its sole administrative discretion, and is contingent upon funds being appropriated thereto. County's failure or delay in performing a capital improvement shall not relieve Lessee of its obligation to make its Capital Contribution Payment. An anticipated capital project list is attached hereto as Exhibit B and incorporated by this reference herein.

6. **Security Deposits**. In consideration for entering into the Lease, and to ensure Lessee's compliance with the terms of the Lease, Lessee has paid County the sum of twenty thousand, seven hundred and eighty-eight dollars ($20,788.00) as a security deposit which represents the first and last month of the Rental Payment. No interest will accrue on the security deposit. With no notice to Lessee, County may claim all or a portion of the security deposit to offset against (1) any unpaid Rental Payment, Revenue Share Payment, or Capital Contribution Payment, (2) any damages arising from Lessee's default under this Lease including, but not limited to, the cost of repairing or remediating damage caused by Lessee to the Premises. Any amounts of the security deposit not claimed by the County will be returned to Lessee within thirty (30) days following termination of this Lease.

7. **Net Lease.** This Lease is a net lease. Except as specifically provided in this Lease, Lessee will be responsible for paying all costs and expenses relating to the Premises, including any personal property taxes, fees, utilities, maintenance, interior and exterior repairs, insurance, and all other costs and expenses relating to the general occupancy and use of the Premises and the Tenant Improvements. Without notice or demand and without abatement, deduction, or setoff except as may be otherwise provided in this Lease, Lessee is required to pay, all sums, impositions, costs, and other payments that Lessee assumes or agrees to pay in any provision of this Lease. If Lessee fails to make a payment, County will have (in addition to all other rights and remedies) all the rights and remedies provided for in this Lease or by law for nonpayment of rent.

8. **Management Obligations**. Lessee shall direct, manage, supervise, and operate the Premises, including the Sales and Service Buildings, Marina, Boat Ramp, and all other related or subsequently constructed facilities. Lessee will employ all personnel necessary for these operations, and perform all other activities necessary to operate and maintain the Premises pursuant to the following:
    a. **Sales and Service Buildings**. Lessee shall be responsible for the daily and routine operation and maintenance of the Sales and Service Buildings.
    b. **Marina**. Lessee shall be responsible for the daily and routine operation and maintenance of the Marina, subject to the following:

i. **Reserved slips**. Lessee shall reserve two (2) boat slips in the Marina for the sole and exclusive use of County, on behalf of the Clackamas County Sheriff's Department.

ii. **Slip Rental Rates**. Slip rental rates may only be increased if mutually agreed to, in writing, by both parties.

iii. **Public access**. Lessee will, to the extent possible, keep the Marina open to the public. Provided, however, that Lessee may restrict access to those portions of the Marina that are under private control, such as slip rentals, are being used for Lessee's business operations, such as operation of concession stands, fueling stations, and similar activities, or that need to be restricted for public health and safety reasons, as determined by Lessee in its reasonable discretion.

c. **Boat Ramp**. Lessee shall be responsible for the daily and routine operation and maintenance of the Boat Ramp. The Boat Ramp is, and will remain during the term of this Lease, open to the public. Lessee shall manage the Boat Ramp consistent with principles of open public access and the County's then-current rules, regulations, ordinances, or policies governing use and access of the Boat Ramp. Any potential restrictions on use or access to the Boat Ramp must be approved, in writing, by the County. Lessee is prohibited from charging a fee or any other charge for use of the Boat Ramp.

9. **Annual Operating Plan**. On or before December 31 of each year of this Lease, Lessee shall cause to be prepared and delivered to County an operating plan for the following year in preliminary draft form setting forth an itemized statement of the estimated receipts and disbursement for the forthcoming fiscal year. The operating plan should include a budget with anticipated revenues, expenditures, and the impact of any new regulatory rules or requirements, fees, or other anticipated or potential events that may have an appreciable impact on revenue or expenditures for a given year. County and Lessee will endeavor to meet monthly throughout the term of this Lease to discuss the status of Lessee's operations and review Lessee's status of implementation of Lessee's operating plan. Provided, however, nothing herein shall be construed as giving County any right of management or control over Lessee's business operations.

10. **Use of Premises**. Lessee may use and occupy the Premises during the Term of this Lease solely for the following purposes:
    a. **Sales and Service Buildings**. Lessee may use the Sales and Service Buildings for the operation of a commercial boat sales and service business, including all uses reasonably related to the same.
    b. **Marina**. Lessee may use the Marina for the operation of a public marina, fuel sales business, and concession business, and all uses reasonably related to the same.
    c. **Boat Ramp**. Lessee may use the Boat Ramp for the operation of a public boat ramp, which uses shall be reserved for public boat launching, boarding access, and boat removal.
    d. **On-Premises Parking**. Lessee may park vehicles in appropriate places on the Premises and shall conform to all applicable laws with respect to such parking.

e. **Adjoining Public Parking**. Lessee and its employees and customers have a nonexclusive right to use the public parking area adjoining the Premises for temporary, short-term day use for parking of vehicles and trailers. Lessee may not use the parking area to store any inventory, including boats and trailers. Lessee's right to use the public parking area shall be in conformance with applicable law. The public parking area is depicted on the map attached hereto as Exhibit E and incorporated by this reference herein.

Any use of the Premises other than those reasonably necessary to those described above is strictly prohibited.

11. Compliance with Legal Requirements. Lessee shall observe and comply with all "Legal Requirements," defined below, that may apply to the Premises, or to the use or manner of uses of the Premises. Lessee will pay all costs of compliance with the Legal Requirements.

"Legal Requirements" means all applicable present and future federal, state, and local laws, ordinances, orders, rules, regulations, codes, and requirements that now or hereafter apply to the Premises, the Improvements, or any component hereof or any activity conducted thereon, including but not limited to those pertaining to Environmental Laws and the use and storage of Hazardous Substances (as these terms are defined below).

"Environmental Laws" means all present or future federal, state, and local laws or regulations related to the protection of health or the environment, including the Resource Conservation and Recovery Act of 1976 (RCRA) (42 USC § 6901 et seq.), the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA) (42 USC § 9601 et seq.), the Toxic Substances Control Act (15 USC § 2601 et seq.), the Federal Water Pollution Control Act (the Clean Water Act) (33 USC § 1251 et seq.), the Clean Air Act (42 USC § 7401 et seq.), amendments to the foregoing, and any rules and regulations promulgated thereunder.

"Hazardous Substances" means any hazardous or toxic substance, material, or waste that is or becomes regulated by any local, state, or federal governmental authority, including without limitation, any hazardous material, hazardous substance, ultra-hazardous material, toxic waste, toxic substance, pollutant, radioactive material, petroleum product, and PCB, as those and similar terms are commonly used or defined by Environmental Laws.

12. Restrictions on Use of the Premises.

a. Lessee shall not use or occupy the Premises, or permit or suffer all or any part of the Premises to be used or occupied: (a) for any unlawful or illegal business, use, or purpose; (b) in any manner so as to constitute a nuisance of any kind; (c) for any purpose or in any way in violation of any Legal Requirements, including Legal Requirements respecting Hazardous Substances; or (d) for any business, use, or purpose deemed disreputable.

b. Lessee shall not cause or permit any waste, damage, disfigurement, or injury to the Premises.

c. Lessee shall not use the Premises in any manner that would conflict with the terms and conditions of this Lease.

d. Lessee shall not engage in any activity that would make it impossible to insure the Premises against casualty, would increase the insurance rate, or would prevent County from taking advantage of any ruling of the Oregon Insurance Rating Bureau, or its successor, allowing County to obtain reduced premium rates for long-term fire insurance policies.

e. Lessee shall refrain from any use that would be reasonably offensive to other tenants, owners, or users of neighboring properties, or that would create a nuisance or damage the reputation of the Premises.

f. Lessee shall not load the electrical system or floors beyond the point considered safe by an engineer or architect selected by County.

g. Lessee shall not make any marks on or attach any sign, insignia, antenna, aerial, or other devise to the exterior or interior walls, windows, or roof of the Premises without the written consent of County.

13. Continuous Operation. Lessee shall occupy, operate, and manage the Premises continuously for the purposes stated herein and, subject to Section 21 below, carry on business during normal business hours. Lessee may close portions of the Premises for brief periods necessary to perform reasonable repairs and maintenance. However, any closure of any portion of the Premises shall, to the maximum extent practical, be performed in a manner that does not interfere with, damage, disturb, hinder, or prevent the use and enjoyment of those portions of the Premises open for public use and access. Lessee may not close portions of the Premises for greater than ten (10) business days without the prior written consent of County.

14. Improvements. Lessee may not make any modifications, alterations, or improvements to the Premises or the Improvements without first obtaining County's prior written consent. Any such modification, alteration, or improvement will be performed in compliance with all Legal Requirements and in a good and workmanlike manner. Unless otherwise agreed to in writing, all modifications, alterations, and improvements will become property of the County.

15. Taxes and Utilities.

a. "Taxes" Defined. As used in this Lease, the terms "Tax" and "Taxes" mean any and all taxes, service payments in lieu of taxes, general or special assessments, excise taxes, transit charges, utility assessments, and any and all charges, levies, fees, or costs, general or special, ordinary or extraordinary, of any kind that are levied or at the direction of laws, rules, or regulations of any federal, state, or local authority on the Premises or the Improvements, or based on or otherwise in connection with the use, occupancy, or operations of the Premises or the Improvements, or with respect to services or utilities in connection with the use, occupancy, or operations of the Premises or the Improvements, or on County with respect to the Premises or the Improvements, or on any act of leasing space in the Improvements, or in connection with the business of leasing space in the

Improvements, including any tax on rents, whether direct or as a part of any "gross receipts" tax, and whether or not in lieu of, in whole or in part, ad valorem property taxes. Taxes will include, but not be limited to, state and local taxes, levies, and assessments, and any tax, fee, or other excise, however described, that may be levied or assessed in lieu of, or as a substitute, in whole or in part, for, or as an addition to any other taxes, and all other governmental impositions and governmental charges of every kind and nature relating to the Premises or the Improvements, including, but not limited to, any road-user or transportation-system-maintenance fee and any charges or fees measured by trip generation or length, parking spaces, impervious surfaces, buildings, vehicle usage, or similar bases for measurement.

b. Payment of Taxes. Except for real property taxes, throughout the Term, Lessee shall pay any Taxes that may be applicable as they become due. If by law any Tax is payable, or may at the option of the taxpayer be paid, in installments, Lessee may pay the same in installments as each installment becomes due and payable, but in any event shall do so before any fine, penalty, interest, or cost may be added for nonpayment of any installment or interest.

c. Contesting Taxes. If Lessee in good faith desires to contest the validity or the amount of any Tax, Lessee may be permitted to do so by giving to County written notice requesting permission to do so before commencement of such contest. If approved, Lessee may contest with respect to the Property and/or the Improvements. County may, at Lessee's expense (including reimbursement of attorney fees reasonably incurred by County), cooperate with Lessee in any such contest to the extent that Lessee may reasonably request, but County shall not be subject to any liability for the payment of any costs or expenses in connection with any proceeding brought by Lessee, and Lessee shall indemnify and save County harmless from any such costs or expenses. Any rebates on account of the Taxes required to be paid and paid by Lessee under the provisions of this Lease shall belong to Lessee, except that to the extent any rebates or refunds are related to a period of time in which this Lease is not in effect (either before commencement or after expiration or termination), the portion of the rebate attributable to such time shall be returned to County to the extent previously paid by County.

d. Evidence of Payment. Promptly after payment, Lessee shall provide County with evidence reasonably satisfactory to County that all Taxes required to be paid by Lessee have been paid.

e. Utilities and Services. Lessee shall pay, directly to the appropriate supplier, for all water, sanitary sewer, storm sewer, gas, electric, telephone, cable, garbage pickup, and all other utilities and services used by Lessee on the Premises as they become due, together with any taxes thereon, from and after the Effective Date. County shall not be in default hereunder nor be liable in damages or otherwise for any failure or interruption of any utility or other service being furnished to the Premises, and no such failure or interruption will entitle Lessee to terminate this Lease.

f. Real property taxes. County will pay any real property taxes and special assessments that may be levied against the Premises.

16. **Insurance**. Lessee shall secure at its own expense and keep in effect during the term of the performance under this Lease the insurance required and minimum coverage indicated below. Lessee shall provide proof of said insurance and name 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: **Clackamas County Parks, 150 Beavercreek Road, Suite 419, Oregon City, OR 97045**

☒ Required - Workers Compensation: Lessee shall comply with the workers' compensation requirements in ORS 656.017, unless exempt under ORS 656.126.
☒ Required – Commercial General Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence, with an annual aggregate limit of $2,000,000 for Bodily Injury and Property Damage.
☒ Required – Professional Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence, with an annual aggregate limit of $2,000,000 for damages caused by error, omission or negligent acts.
☒ Required – Automobile Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence for Bodily Injury and Property Damage.

This policy(s) shall be primary insurance as respects to County. Any insurance or self-insurance maintained by County shall be excess and shall not contribute to it. Any obligation that County agree to a waiver of subrogation is hereby stricken.

17. **Responsibility for Damages; Indemnity**.

Lessee shall be in exclusive control of the Premises. Lessee shall be solely responsible for all damage to property, injury to persons, and loss, expense, inconvenience, and delay which may be caused by, or result from, use of the Premises, or from any act, omission, or neglect of Lessee, its subcontractors, agents, or employees.

To the fullest extent permitted by law, Lessee agrees to indemnify, hold harmless and defend County, and its officers, elected officials, agents and employees from and against all claims and actions, and all expenses incidental to the investigation and defense thereof, arising out of or based upon damage or injuries to persons or property caused by the errors, omissions, fault or negligence of Lessee or Lessee's employees, subcontractors, or agents. However, neither Lessee nor any attorney engaged by Lessee 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 Lessee 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.

18. Liens.

a. **No Liens**. Lessee shall not suffer or permit any construction liens to attach to or be filed against any part of the Premises owned by County by reason of any work, labor, services, or materials done for, or supplied to, or claimed to have been done for or supplied to, Lessee or any person occupying or holding an interest in any part of the Premises or the Improvements owned by Lessee. If any such lien is filed against any portion of the Premises or the Improvements, Lessee shall cause the same to be discharged of record within 15 days after the date of its filing by payment, deposit, or bond.

b. **County Right to Post Notices**. County may post and keep posted at all reasonable times on the Premises notices of non-responsibility and any other notices that County desires or is required to post for the protection of County's interest in the Premises from any such lien.

c. **No Right to Lien County's Interest**. Nothing in this Lease may be deemed to be, or be construed in any way as constituting, the consent or request of County, express or implied, by inference or otherwise, to any person, firm, or corporation for the performance of any labor or the furnishing of any materials for any construction, rebuilding, alteration, or repair of or to the Premises, or as giving Lessee any right, power, or authority to contract for or permit the rendering of any services or the furnishing of any materials that might in any way give rise to the right to file any lien against County's interest in the Premises or against County's interest, if any, in the Improvements. Lessee shall not be an agent for County.

19. Repairs and Maintenance.

a. **Lessee's Obligation**. Except as expressly provided in Section 19(b), below, Lessee, at its sole expense, must maintain, repair, and replace the Premises and the County-owned Improvements as and when needed so as to keep them clean and in good in good condition and repair, throughout the entire Term. Lessee's obligations extend solely to nonstructural items, all tenant-owned improvements, and to all ordinary maintenance, repair, and replacement work. All of Lessee's maintenance, repairs, and replacements required under this Lease shall be performed in a good and workmanlike manner, of a quality at least equal to the original work, and shall be in compliance with all standards and requirements of law, licenses and municipal ordinances. Lessee's obligations includes, but are not limited to, the repairs described in Exhibit C, attached hereto and incorporated by this reference herein.

b. **County's Obligation**. Consistent with Section 6 of this Lease, County is not required to furnish to Lessee or the Premises any facilities, utilities, or services of any kind whatsoever during the Term of this Lease except for significant structural repairs, maintenance, or upgrades. A list of structural repairs, maintenance, or upgrades that County anticipates will be performed during the Term of this Lease is attached hereto as Exhibit B and incorporated by this reference herein.

   In performing its obligations hereunder, County shall have exclusive access to all or a portion of the Premises.

20. **Inspection and Access**. County may enter onto the Premises at reasonable times during reasonable business to perform inspections, to inspect and take measurements, samples or other activities to access any potential contamination issues, to perform repairs and maintenance under Section 19, above, and to ensure compliance with the terms of this Lease. Nothing in this Lease implies any duty or obligation, however, on County's part to make such inspections or perform such work unless County is otherwise obligated to do so under this Lease. County's performance of any work will not constitute a waiver of Lessee's default in failing to perform the same.

21. **Closures**.
    a. **Generally**. County may, in its reasonable discretion, close all or a portion of the Premises, and exclude Lessee from use thereof, for the following reasons:
        i. High-water events that cause the river to exceed or overtop the Boat Ramp;
        ii. Any closures of roads providing access to all or a portion of the Premises due to flooding from high water or for debris removal activities;
        iii. County's inspection of all or a portion of the Premises, including regular Boat Ramp inspections;
        iv. Performance of any repair or maintenance described under Section 19, above.
    b. **No liability**. County will endeavor to minimize the impact of closing all or a portion of the Premises to the maximum extent practicable. However, Lessee shall have no right to offset any payment obligation under this Lease as a result of a closure under this Section 21. County shall have no liability for any damages arising from a closure under this Section 21, including any damages for lost profits, expense, inconvenience, delay, or any indirect, incidental, consequential or special damages arising from, or related to, such a closure.

22. **Damage and Destruction**. If any Lessee owned Improvement(s) on the Premises are damaged or destroyed by flood, fire or other casualty, Lessee's obligations under the lease will not abate and Lessee shall promptly determine whether to repair, replace, reconstruct, demolish or abandon the Improvement(s). Lessee shall promptly inform County of its decision and its proposed plan of action. Should the Lessee decide to abandon or demolish the damaged Lessee owned Improvement(s), Lessee shall at Lessee's expense clear the remains of the Improvement(s) from the premises unless otherwise directed by County.

23. **Condemnation**. The Parties expressly acknowledge and understand that the Premises may be subject to condemnation by right of eminent domain as a result of one or more potential projects including, but not limited to, the French Prairie Bridge Crossing project. In the event the Premises is subject to condemnation by right of eminent domain by any federal, state, or local agency, the following provisions shall govern.
    a. **Total Taking**. If all the Premises is taken or condemned by right of eminent domain or by purchase in lieu of condemnation (a "Taking"), or if in Lessee's reasonable judgment the Taking of any portion of the Premises renders the portion remaining insufficient and unsuitable to permit the restoration of the

Improvements following the Taking, then either party may terminate this Lease by providing written notice thereof within 30 days after the terminating party is notified of the Taking, in which case the Lease will cease and terminate (except those provisions intended to survive the expiration or termination of the Lease) and Lessee shall vacate the Premises as of the date on which the condemning authority takes possession (any Taking in this section being called a "Total Taking").

b. **Partial Taking and Award for Partial Taking**. If, during the Term, there is a Taking of the Premises, but the Taking is not a Total Taking and not a temporary taking of the kind described below, this Lease will not terminate but will remain in full force and effect with respect to the portion of the Premises not taken.
c. **Temporary Taking**. If there is a Taking of all or a part of the Premises for temporary use, this Lease will continue without change, as between County and Lessee, and Lessee will be entitled to the entire award made for that use.
d. **Award for Total Taking**. It is specifically understood and agreed that County shall be entitled to all of the proceeds of a Total or Partial Taking, and Lessee shall have no claim against County as a result of condemnation. Lessee shall be entitled to the relocation benefits, if any, and all the proceeds of condemnation which are on account of the taking of the improvements, equipment, fixtures or personal property, if any, belonging to Lessee.
e. **Dispute Resolution**. In the event of any dispute between Lessee and County regarding any issue of fact arising out of a Taking mentioned in this Article, the dispute shall be resolved by the same court in which the condemnation action is brought, in any proceedings that are appropriate for adjudicating the dispute.

24. **Assignment and Subletting.** Lessee shall not sell, assign, sublet, grant, or transfer this Lease, or any portion of Lessee's interest therein, without the prior written consent of County. Any attempted assignment or sublet without such prior written consent will be void. County's consent to an assignment or sublease will in no event release Lessee from its liabilities or obligations under this Lease, nor relieve Lessee from the requirement of obtaining County's prior written consent to any further assignment or sublease. County's acceptance of Rental Payments, Revenue Share Payment, or Capital Contribution Payments from any other person will not be deemed to be a waiver by County of any provision of this Lease or consent to any assignment or sublease.

25. **Sale of Premises.** County may actively market the Premises for sale at any time during the Term of this Lease. Upon sale of the Premises during the Term of this Lease or any extensions, this Lease shall be terminated. County shall not agree to any sale terms that shorten the notice of termination period required to be given to Lessee under this Lease.

26. **State Lease Sublease**. The Premises includes tidelands leased by County from the State of Oregon for purposes of operating and accessing moorage facilities under that certain lease described as 10937-ML (the "State Tideland Lease"), a copy of which is attached hereto as Exhibit D and incorporated by this reference herein. County hereby subleases to Lessee County's interest under the State Tideland Lease. Lessee shall comply with all terms and conditions of the State Tideland Lease throughout the term of this Lease. County will pay the fees due and owing under the State Tideland Lease.

27. Default. The following constitute a default under this Lease:

- **a.** Lessee's failure to pay any amount required to be paid by Lessee to County under this Lease within 10 days after written notice of such nonpayment is given to Lessee;
- **b.** Lessee's violation of any term or condition in this Lease following 10 days' notice and opportunity to cure, after written notice of such violation;
- **c.** Lessee's failure to occupy the Premises for one or more of the purposes permitted under this Lease for a period of ten (10) business days or more, unless such failure is excused by County;
- **d.** Lessee becomes insolvent, makes an assignment for the benefit of creditors, a receiver is appointed for Lessee's properties.

28. Termination.

- **a. Non-default Termination**. This Lease may be terminated for the following non-default reasons:
  - i. By mutual agreement of the parties;
  - ii. By County for the following reasons:
    1. Upon one hundred and eighty (180) days' written notice to Lessee, for convenience provided, however, that County may not terminate for convenience during the first two (2) years of the Lease; or
    2. If County fails to receive expenditure authority sufficient to allow County, in the exercise of its reasonable administrative discretion, to continue to perform under this Lease; or
    3. If federal or state laws, regulations or guidelines are modified or interpreted in such a way that performance under this Lease is prohibited.
  - iii. Upon one hundred and eighty (180) days' written notice to County, by Lessee for convenience subject to the following terms and conditions:
    1. Lessee may not terminate this Lease for convenience during the first two (2) years of the Lease;
    2. The termination of the Lease may not occur from July 1 through October 1 of any given year of the Lease. Any notice of termination that would have the effect of terminating the Lease during this time period shall automatically be extended to October 2. Lessee shall remain responsible for all obligations under this Lease until the October 2 termination date.

- **b. Termination for Default**. Upon occurrence of an event of default and failure to cure, if permitted, County may immediately terminate this Lease upon written notice to Lessee and exercise any remedy provided herein.

29. Remedies.

- **a.** Upon the occurrence of an event of default, County may exercise any one or more of the remedies set forth in this section or any other remedy available under applicable law or contained in this Lease:

i. **Termination**. County may terminate this Lease by written notice to Lessee, which is effective immediately.

ii. **Removal**. County or County's agent or employee may immediately or at any time thereafter, with or without terminating the Lease, at County's sole discretion, reenter the Premises either by summary eviction proceedings or by any suitable action or proceeding at law, or by force or otherwise, without being liable to indictment, prosecution, or damages, and may repossess the same, and may remove any person from the Premises, to the end that County may have, hold, and enjoy the Premises and the Improvements.

iii. **Reletting**. County may relet the Premises, but County shall not be required to relet the Premises for the purposes specified in the Lease or which purposes County may reasonably consider injurious to the Premises, or to any lessee that County may reasonably consider objectionable. County may relet all or part of the Premises, alone or in conjunction with other properties, for a term longer or shorter than the term of this Lease, on any reasonable terms and conditions County determines, in its sole discretion, to be in the County's best interest. To the extent allowed under Oregon law, County shall not be liable for refusing to relet the Premises or, in the event of reletting, for refusing or failing to collect any rent due on such reletting; and any action of County will not operate to relieve Lessee of any liability under this Lease or otherwise affect such liability. County at its option may make any physical change to the Premises that County, in its sole discretion, considers advisable and necessary in connection with any reletting or proposed reletting, without relieving Lessee of any liability under this Lease or otherwise affecting Lessee's liability.

iv. **Damages**. Whether or not County retakes possession of or relets the Premises, County may recover its damages from Lessee, including without limitation, all lost rentals and all costs incurred by County in restoring the Premises or otherwise preparing the Premises and for reletting, and all costs incurred by County in reletting the Premises.

v. **Right to Sue More than Once**. County may sue periodically to recover damages during the period corresponding to the remainder of the Term, and no action for damages shall bar a later action for damages subsequently accruing.

vi. **Self-Help**. If Lessee at any time (a) fails to pay any Tax in accordance with the provisions of this Lease, (b) fails to make any other payment required under this Lease, or (c) fails to perform any other obligation on its part to be made or performed under this Lease, then after 10 days' written notice to Lessee (or without notice in the event of an emergency) and without waiving or releasing Lessee from any obligation of Lessee contained in this Lease or from any default by Lessee and without waiving County's right to take any action that is permissible under this Lease as a result of the default, County may, (i) pay any Tax or make any other payment required of Lessee under this Lease, and (ii) perform any other

act on Lessee's part to be made or performed as provided in this Lease, and may enter the Premises and the Improvements for any such purpose, and take any action that may be necessary. All payments so made by County and all costs and expenses incurred by County in connection with the performance of any such act will constitute additional costs payable by Lessee under this Lease and must be paid to County on demand. In no instance shall Lessee be entitled to attorney's fees relating to any default, remedy or self-help, even if it is determined that County did not act appropriately with respect to the same.

vii. **All Other Remedies**. the County shall have any remedy available to it in law or equity, whether or not specified herein.

b. **No Waiver.** No failure by County to insist on the strict performance of any agreement, term, covenant, or condition of this Lease or to exercise any right or remedy consequent upon a breach, and no acceptance of full or partial Rental Payments, Revenue Share Payments, or Capital Contribution Payments during the continuance of any such breach, constitutes a waiver of any such breach or of such agreement, term, covenant, or condition. No agreement, term, covenant, or condition to be performed or complied with by Lessee, and no breach by Lessee, may be waived, altered, or modified except by a written instrument executed by County. No waiver of any breach will affect or alter this Lease, but each and every agreement, term, covenant, and condition of this Lease will continue in full force and effect with respect to any other then-existing or subsequent breach.

c. **Remedies Cumulative and Nonexclusive.** Each right and remedy provided for in this Lease is cumulative and is in addition to every other right or remedy provided for now or hereafter existing at law or in equity or by statute or otherwise, and County's or Lessee's exercise or beginning to exercise of any one or more of the rights or remedies provided for in this Lease or now or hereafter existing at law or in equity or by statute or otherwise will not preclude the simultaneous or later exercise by the party in question of any or all other rights or remedies provided for in this Lease or now or hereafter existing at law or in equity or by statute or otherwise.

30. Surrender and Holdover.

a. **Condition of Premises and Improvements.** Upon expiration of the Term or earlier termination of this Lease, Lessee shall deliver to County the Premises in good condition, free and clear of all occupancies other than subleases to which County has specifically consented and free and clear of all liens and encumbrances other than those, if any, existing on the date of this Lease or created or suffered by County. Lessee shall surrender the Premises and County-owned Improvements in good condition and repair (reasonable wear and tear excepted), free and clear of all occupancies other than subleases to which County has specifically consented and free and clear of all liens and encumbrances other than those, if any, existing on the date of this Lease or created or suffered by County. Lessee shall be solely responsible for the removal or remediation, in compliance with all Legal Requirements, of any Hazardous Substances on the Premises.

b. **Lessee's Property.** Before the expiration or earlier termination of this Lease, Lessee shall remove all Lessee owned Improvements, furnishings, furniture, and trade fixtures that remain Lessee's property (the "Lessee's Property"). If Lessee fails to do so, at County's option, (a) the failure to remove Lessee's Property will be deemed an abandonment of Lessee's Property, and County may dispose of Lessee's Property in any manner permitted by law; or (b) by written notice given to Lessee, County may elect to hold Lessee to Lessee's obligation of removal, in which case County may remove, transport, and store Lessee's Property and Lessee shall reimburse County for the costs incurred in connection therewith on demand.

c. **Holdover.** There shall be no holdover permitted under this Lease.

31. Notice. All notices given pursuant to this Lease shall be in writing and shall either be (i) mailed by first class mail, postage prepaid, certified or registered with return receipt requested, or (ii) delivered in person or by nationally recognized overnight courier, or (iii) sent by email.

Lessee	County
Administrator: River City Boats Attn: Tim Coleman Phone: 503-797-2222 Email: tim@rivercityboatsales.com Administrator: River City Boats Attn: Ken Guerins Phone: 503-797-2222 Email: ken@rivercityboatsales.com	Administrator: Clackamas County Parks Manager Attn: Rick Gruen Phone: 503.742.4345 Email: rgruen@clackamas.us Administrator: Business and Community Services Director Attn: Laura Zentner Phone: 503.742.4351 Email: LZentner@clackamas.us

32. General Terms and Conditions.

a. **Relationship.** Nothing contained in this Lease will create a joint venture or partnership, establish a relationship of principal and agent, establish a relationship of employer and employee, or any other relationship of a similar nature between County and Lessee.

b. **Independent Contractor**. The service(s) to be rendered under this Lease are those of an independent contractor. Although the County reserves the right to determine work to be performed and to evaluate the quality of the completed performance, County cannot and will not control the means or manner of Lessee's performance. Lessee is responsible for determining the appropriate means and manner of performing under this Lease. Lessee is not to be considered an agent or employee of County for any purpose. This Lease is not intended to entitle the Lessee 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.

c. Waiver. Failure of either party at any time to require performance of any provision of this Lease shall not limit the party's right to enforce the provision. Waiver of any breach of any provision shall not be waiver of any succeeding breach of the provision or waiver of the provision itself or any other provision.

d. Integration. Except as otherwise set forth herein, this Lease constitutes the entire agreement between the parties on the subject matter of this Lease. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Lease.

e. Further Assurances. The parties to this Lease agree to execute and deliver such additional documents and to perform such additional acts as may be reasonably necessary to give effect to the terms and provisions contemplated herein.

f. Survival. All rights and obligations shall cease upon termination or expiration of this Lease except for the rights and obligations set forth in Sections 6, 11, 12, 14, 15, 17, 18, 22, 27, 29, 30, and 32, and all other rights and obligations which by their context are intended to survive.

g. Invalidity. If any term or provision of this Lease or the application of the Lease to any person or circumstance is, to any extent, held to be invalid or unenforceable, the remainder of this Lease, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, will not be affected, and each term and provision of this Lease will be valid and be enforced to the fullest extent permitted by law.

h. Force Majeure. If either party's performance of an obligation under this Lease (excluding a monetary obligation) is delayed or prevented in whole or in part by (a) any Legal Requirement (and not attributable to an act or omission of the party); (b) any act of God, fire, or other casualty, flood, storm, explosion, accident, epidemic, war, terrorism, civil disorder, strike, or other labor difficulty; (c) shortage or failure of supply of materials, labor, fuel, power, equipment, supplies, or transportation; or (d) any other cause not reasonably within the party's control, whether or not the cause is specifically mentioned in this Lease, the party will be excused, discharged, and released of performance to the extent that such performance or obligation (excluding any monetary obligation) is so limited or prevented by the occurrence without liability of any kind.

i. Non-Waiver of Governmental Rights. Subject to the terms and conditions of this Lease, County is specifically not obligating itself with respect to any discretionary action relating to the Premises including, but not limited to, condemnation, comprehensive planning, rezoning, variances, environmental clearances or any other governmental approvals that are or may be required.

j. Entire Agreement; Counterparts. This Lease contains the entire agreement between the parties and, except as otherwise provided, can be changed, modified, amended, or terminated only by an instrument in writing executed by the parties. Lessee and County mutually acknowledge and agree that there are no verbal agreements or other representations, warranties, or understandings affecting this Lease. This Lease may be executed in any number of counterparts, including by

fax signatures, each of which will constitute an original, but all of which will constitute one Lease.

k. Binding Effect. The covenants and agreements contained in this Lease are binding on and inure to the benefit of County, Lessee, and their respective successors.

l. Recordation of Lease. County may elect that a copy of this Lease or a memorandum of it, executed and acknowledged by both parties, be recorded in the public records of Clackamas County, Oregon. Lessee will pay the recording costs.

m. Time Is of the Essence. Time is of the essence as to the performance of this Lease.

n. No Third Party Beneficiaries. County and Lessee are the only parties to this Lease and are the only parties entitled to enforce its terms. Nothing in this Lease 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 Lease.

o. Access to Records. Lessee 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 Lease. County and its duly authorized representatives shall have access to the books, documents, papers, and records of Lessee, which are directly pertinent to this Lease for the purpose of making audit, examination, excerpts, and transcripts. Lessee 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 Lease, or until the conclusion of any audit, controversy or litigation arising out of or related to this Lease, whichever date is later.

p. Governing Law. This Lease, 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 Lessee that arises out of or relates to the performance of this Lease 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 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. Lessee, by execution of this Lease, hereby consents to the personal jurisdiction of the courts referenced in this section.

q. 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.

r. **Limitation of Liabilities.** This Lease 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. Neither party shall be liable for any indirect, incidental, consequential or special damages under this Lease or any damages of any sort arising solely from the termination of this Lease in accordance with the non-default termination provisions of Section 28(a).

s. **Merger.** This Lease 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 Lease. No amendment, consent, or waiver of terms of this Lease 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. Lessee, by the signature hereto of its authorized representative, agrees to be bound by the terms and conditions of this Lease.

[Signature Pages to Follow]

IN WITNESS WHEREOF, Clackamas County has caused this instrument to be executed by duly elected officers this ____ day of April, 2020.

CLACKAMAS COUNTY

By: _____
Chair of the Board of County Commissioners

STATE OF OREGON)
) ss.
County of Clackamas)

On this ____ day of April, 2020, before me the undersigned, a notary public in and for such state, the foregoing instrument was acknowledged before me by _____, Chair of the Board of County Commissioners on behalf of Clackamas County.

Notary Public for Oregon
My Commission Expires:_____

IN WITNESS WHEREOF, River City Boat Sales, LLC has caused this instrument to be executed by duly elected officers this ____ day of April, 2020.

River City Boat Sales, LLC

By: _____
Its: _____

STATE OF OREGON)
) ss.
County of Clackamas)

On this ____ day of April, 2020 before me the undersigned, a notary public in and for such state, the foregoing instrument was acknowledged before me by _____, the _____, on behalf of River City Boat Sales, LLC.

Notary Public for Oregon
My Commission Expires:_____

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

In the Matter of a Lease of Property to River City Boat Sales, LLC Described as the Boones Ferry Marina in Clackamas County, Oregon	}	Board Order No. _____ *Page 1*

Whereas, Clackamas County owns property generally described as follows: Tax Lots 31W23DC02000, 900 and 800, more commonly known as Boones Ferry Marina, 26117/26177 Boones Ferry Landing, Aurora, OR 97002 (the "Property"); and

Whereas, River City Boat Sales, LLC desires to lease the Property; and

Whereas, River City Boat Sales, LLC is willing to agree to the terms and conditions set forth in the Commercial Lease attached to this Order as Exhibit "A"; and

Whereas, ORS 271.360 requires leases to be authorized by ordinance or order of the public body executing the same; now therefore,

IT IS HEREBY ORDERED that the Chair of the Clackamas County Board of Commissioners is authorized to execute the Commercial Lease attached to this Order as Exhibit "A".

DATED this __ day of _____, 2020.

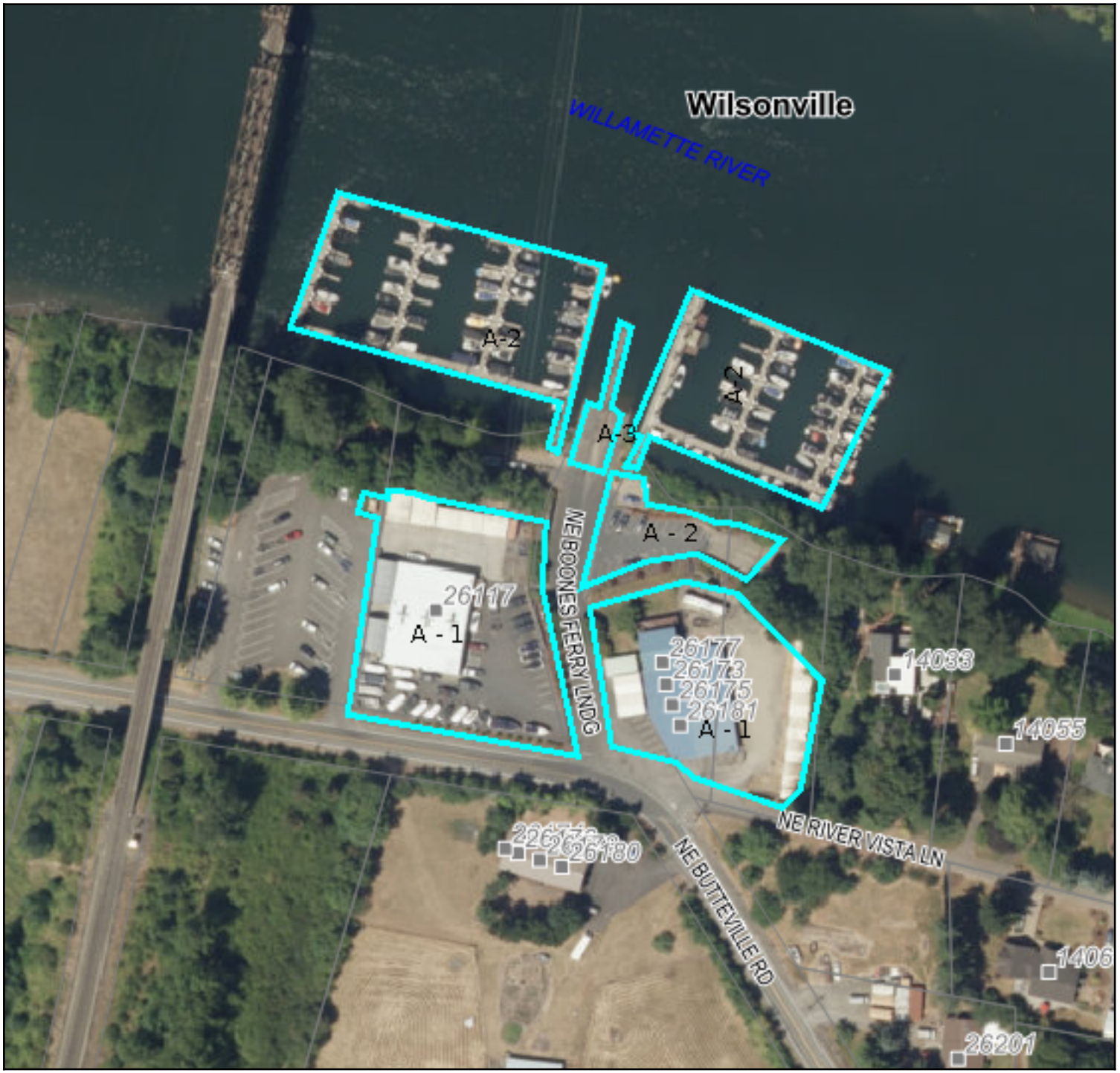
BOARD OF CLACKAMAS COUNTY COMMISSIONERS

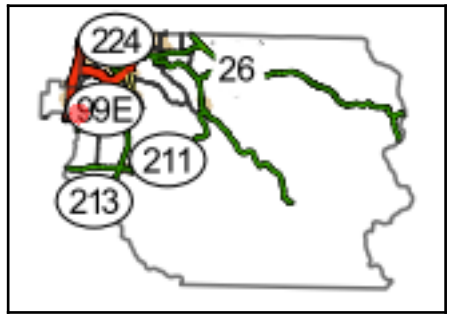
_____
Chair

_____
Recording Secretary

Clackamas County

EXHIBIT A





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Clackamas County

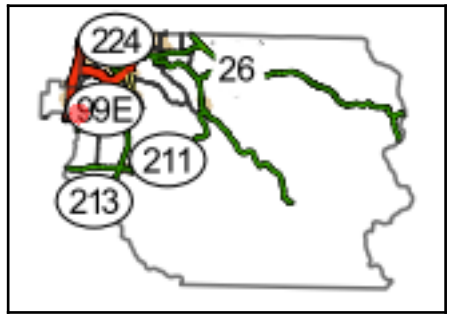
Geographic Information Systems
168 Warner Milne Road
Oregon City, OR 97045

This map and all other information have been compiled for preliminary and/or general purposes only. This information is not intended to be complete for purposes of determining land use restrictions, zoning, title, parcel size, or suitability of any property for a specific use. Users are cautioned to field verify all information

Wed, 25 Mar 2020 08:14:06

Clackamas County

EXHIBIT A (1-4)



Clackamas County

Geographic Information Systems
168 Warner Milne Road
Oregon City, OR 97045

Wed, 25 Mar 2020 10:08:53

Exhibit B

Anticipated Boones Ferry Marina Capital Improvement Plan

CAPITAL PROJECTS LIST

Roof Repair/Replacement (Service Bldg)
Roof Repair/Replacement (Sales Bldg)
Electrical Panel Upgrade (Service Bldg)
Asphalt Paving - main drive/road apron
Storm Drain / Gutters / Winterization
Asphalt surface - Sales Storage Area
Well Collar - Sales Parking Lot
Fuel Tank Cleanup
Boarding Dock Replacement
General Dock Upgrades
Bank Stabilization
Exterior Painting/Fascia replacement
Bathrooms (TI) - Sales Bldg
Apartment Modifications (TI)

EXHIBIT C

Boones Ferry Marina Operating and Maintenance Plan

Task	Responsibility		
	County	Lessee	Shared*
Monitor driftwood buildup on marina docks		x	
Monitor driftwood buildup on launch dock		x	
Pike pole/skim driftwood/debris		x	
Remove driftwood from marina docks			x
Remove driftwood from launch dock			x
Blow off parking lots/rake leaves	x		
Monitor for flood damage		x	
Repair flood damage, remove silt			x
Re-center launch dock post flood		x	
Start up water system	x		
Repair broken water lines	x		
Repair broken/detached faucets		x	
Test backflow prevention devices	x		
Water system testing	x		
Pressure wash docks		x	
Repair/replace marina dock components			x
Dock components cleaning and maintenance		x	
Repair/replace dock boxes	x		
Repair/replace launch dock components	x		
Seasonal re-connect fuel line to dock	x		
Start up other fuel system components		x	
Fuel system maintenance and servicing		x	
Start up sanitary pumpout system	x		
Garbage dumpster, coordinate		x	
Garbage dumpster, pay for	x		
Porta-Potty Service, coordinate		x	
Porta-Potty Service, pay for	x		
Clean up landscaping			x
Parking lot maintenance			x
Check/repair/replace/update park signage	x		
Check/repair/replace/update marina signs		x	
Pick up litter, empty garbage, remove items		x	

Task	Responsibility		
	County	Lessee	Shared*
Open overflow lot			x
Parking and fee enforcement	x		
Fee collection and processing	x		
Keep up landscaping and appearance			x
Monitor and repair marina dock components			x
Monitor and repair launch dock components			x
Routine testing of sanitary pumpout system	x		
Keep marina docks clean		x	
Keep launch dock clean		x	
Water system testing	x		
Winterize water system	x		
Winterize sanitary pumpout system	x		
Seasonal disconnect fuel line from dock	x		
Shut down/winterize fuel system components		x	
Close overflow lot			x
Move porta-potty out of flood area		x	
Remove fire extinguisher(s) from flood area		x	
Pump septic holding tank	x		

* Shared responsibility generally means the Lessee will monitor issues, address minor repairs or projects and deal with quick on-site response to emerging issues, and report complex issues or major repairs to County for resolution.

STATE OF OREGON
DEPARTMENT OF STATE LANDS
AMENDED AND RESTATED
SUBMERGED AND SUBMERSIBLE LAND LEASE

10937-ML

This Lease is an amendment to and restatement of that certain submerged and submersible lands lease, ML-9300/10937-ML, dated the 31st day of March, 1995 and amended on April 5, 1999, by and between the State of Oregon, by and through the Oregon State Land Board and the Department of State Lands, and Clackamas County Parks, as lessee:

The State of Oregon, by and through the Oregon State Land Board and the Department of State Lands ("State"), hereby leases to the person(s) herein named ("Lessee"), the following described lands on the terms and conditions stated herein (the "Lease"):

NAME of LESSEE:
Clackamas County Parks
Attn: Rick Gruen, Parks Manager

ADDRESS:
150 Beavercreek Rd, Suite 419
Oregon City, OR 97045

Legal classification of Lessee is a Political Subdivision,

Lands situated in Clackamas County more fully described as follows:

All state-owned submerged lands in the Willamette River in Section 23, Township 3 South, Range 1 West, Willamette Meridian, Clackamas County, Oregon, more particularly described as follows:

PARCEL A

Commencing at a point on the intersection of the Westerly line of Tax Lot 2100 (Clackamas County Assessor's Map Number 3 1W 23DC) and the line of Ordinary High Water on the left bank of the Willamette River;

thence riverward along a line perpendicular to the thread of the stream to the line of Ordinary Low Water and the TRUE POINT OF BEGINNING;

thence continuing riverward along said perpendicular line a distance of 150 feet;

thence downstream and 150 feet parallel to said line of Ordinary Low Water a distance of 300 feet, more or less, to a point which lies 150 feet riverward from the line of Ordinary Low Water as extended perpendicular to the thread of the stream from a point which is the intersection of the Easterly line of Tax Lot

2000 (Clackamas County Assessor's Map Number 3 1W 23DC) and the line of Ordinary High Water;

thence shoreward along said perpendicular line a distance of 150 feet to the line of Ordinary Low Water;

thence upstream along said line of Ordinary Low Water a distance of 300 feet, more or less, to the TRUE POINT OF BEGINNING, containing 1.03 acres, more or less.

PARCEL B

Commencing at a point on the intersection of the Westerly line of Tax Lot 900 (Clackamas County Assessor's Map Number 3 1W 23DC) and the line of Ordinary High Water on the left bank of the Willamette River;

thence riverward along a line perpendicular to the thread of the stream to the line of Ordinary Low Water and the TRUE POINT OF BEGINNING;

thence continuing riverward along said perpendicular line a distance of 150 feet;

thence downstream and 150 feet parallel to said line of Ordinary Low Water a distance of 210 feet, more or less, to a point which lies 150 feet riverward from the line of Ordinary Low Water as extended perpendicular to the thread of the stream from a point which is the intersection of the Easterly line of Tax Lot 800 (Clackamas County Assessor's Map Number 3 1W 23DC) and the line of Ordinary High Water;

thence shoreward along said perpendicular line a distance of 150 feet to the line of Ordinary Low Water;

thence upstream along said line of Ordinary Low Water a distance of 210 feet, more or less, to the TRUE POINT OF BEGINNING, containing 0.72 acres, more or less.

Total number of acres: 1.75 acres or 76,230 square feet, more or less.

Hereinafter referred to as the "Leasehold".

SECTION 1 - LEASE TERM; RENEWAL; TERMINATION

1.1 Term: This Lease will continue for a period of 15 years commencing on October 1, 2014, the month and date of which will be known as the "Lease Anniversary Date," and expiring on September 30, 2029, unless terminated earlier as provided under Section 1.4 or Section 7.2 below.

1.2 Renewal: Lessee may apply to renew this Lease for successive 15 year terms by submitting a completed lease renewal application form to State not less than 180

days prior to the expiration of the current term. Upon receipt of the application, State shall renew this Lease unless:

1.2.1 State determines, in its sole discretion, that Lessee has not complied with the terms of this Lease, the applicable statutes or Oregon Administrative Rules; or

1.2.2 Lessee is no longer the preference right holder as provided in ORS 274.040(1) and defined in OAR 141-082-0255; or

1.2.3 State determines that the renewal of this Lease for all or any portion of the Leasehold would be contrary to local, state, or federal law, or would be inconsistent with the policies set forth in OAR 141-082-0260.

1.3 Notice of Intent Not to Renew: Except as otherwise provided in this Lease, State shall provide written notice to Lessee two years in advance if State intends not to renew this Lease for all or any portion of the Leasehold. If State determines not to renew this Lease, but less than two years remain in the Lease term, State shall, at Lessee's request, extend the term of this Lease to complete the two year notice period, within which time Lessee shall vacate that portion of the Leasehold upon which the Lease is not being renewed and relocate any sublessees in an orderly fashion.

1.4 Termination Upon Mutual Consent: This Lease may be terminated by mutual written consent of Lessee and State.

1.5 Holdover: If Lessee does not vacate the Leasehold at the expiration or upon termination of the Lease, State may treat Lessee as a tenant from month to month, subject to all of the provisions of this Lease except the provisions for term, renewal, and Rent. State may unilaterally establish a new Rent for the month-to-month tenancy, payable monthly in advance. If a month-to-month tenancy results from holdover by Lessee under this Section, the tenancy will be terminable at the end of any monthly rental period upon Notice from State given not less than 30 days prior to the termination date specified in the Notice.

SECTION 2 – RENT; OTHER ASSESSMENTS

2.1 Initial Annual Rent: The rental payment to be paid by Lessee to State (the "Rent") for the first year of the Lease is $2,081.08, based on the following Flat Rate. Receipt of the first year's Rent is hereby acknowledged.

Use Class	Area (square ft.)	Rate Choice	Annual Rent
Commercial Marina/Moorage	76,230 square feet	Flat Rate	$2,081.08
		TOTAL	$2,081.08

2.2 Annual Rent Adjustment: The Rent will be adjusted annually in accordance with the provisions of OAR 141-082-0305 in effect at the time. Each payment is due on the Lease Anniversary Date established in Section 1.1.

2.3 Address for Rent Payments: Until State provides notice of a change in address (using a method described in Section 10.4), Lessee shall deliver all Rent payments to the following address:

Department of State Lands
775 Summer St. NE, Suite 100
Salem, OR 97301-1279

2.4 Assessments: Lessee shall pay all taxes or assessments, or both, that are levied against the Leasehold, whether or not such taxes or assessments, or both, have been levied in the past against the Leasehold or State by the assessing agency.

2.5 Liens: With the exception of mortgages or other security interests authorized by State under Section 6, Lessee shall immediately cause to be discharged any lien or other charge placed on the Leasehold or its Improvements, arising directly or indirectly out of Lessee's actions. State may terminate this Lease if Lessee fails to discharge any lien or charge or provide State with a sufficient bond covering the full amount of the lien after ten days Notice to do so by State. Lessee shall pay and indemnify State for all costs, damages or charges of whatsoever nature, including attorney's fees, necessary to discharge such liens or charges whether the costs, damages or charges are incurred prior or subsequent to any termination of this Lease.

2.6 Late Charges and Interest: Late payments by Lessee of Rent and other charges due under the Lease will cause State to incur costs and other damages not otherwise addressed in this Lease, the exact amount of which will be difficult to ascertain, including costs associated with administrative processing and accounting. In recognition of the foregoing, the parties agree that, notwithstanding other remedies permitted under the Lease and in addition to these remedies, if Lessee has not made full payment of amounts due within 20 days of the date payment is due, Lessee shall pay an additional charge equal to five percent of the amount of the late Rent or other charge. In addition, all amounts due and owing under this Lease, including late charges, will bear interest at the lower of: (a) the highest interest rate allowable by law, or (b) 12% per year.

SECTION 3 - USE AND RESTRICTIONS ON USE

3.1 Authorized Use: This Lease grants to Lessee the right to use the Leasehold for the specific purpose(s) described below in accordance with the Lease terms and conditions, applicable local (including local comprehensive land use planning and zoning ordinances), state and federal laws and the applicable Oregon Administrative Rules.

Commercial Marina/Moorage and Floating Home Moorage

3.2 Restrictions on Use: Lessee shall:

3.2.1 comply with all applicable local, state and federal laws and regulations affecting the Leasehold and its use, including local comprehensive land use planning and zoning ordinances, and correct at Lessee's own expense any failure of compliance created through Lessee's fault or by reason of Lessee's use;

3.2.2 dispose of all waste in a proper manner and not allow debris, garbage or other refuse to accumulate within the Leasehold, and, if Lessee allows debris, garbage or other refuse to accumulate within the Leasehold, allow State to remove the debris, garbage and other refuse, and collect the cost of such removal from Lessee;

3.2.3 not cut, destroy or remove, or permit to be cut, destroyed or removed, any vegetation that may be upon the Leasehold except with written permission of State, and promptly report to State the cutting or removal of vegetation by other persons;

3.2.4 conduct all operations within the Leasehold in a manner which conserves fish and wildlife habitat, protects water quality, and does not contribute to soil erosion or the growth of noxious weeds;

3.2.5 maintain all buildings, docks, pilings, floats, gangways, similar structures, or other improvements (each an "Improvement") in a good state of repair; and

3.2.6 not unreasonably interfere with the public's trust rights of commerce, navigation, fishing or recreation.

3.3 Condition of Leasehold and Improvements: Lessee represents that it has inspected the Leasehold and Improvements, if any, and accepts the Leasehold and all Improvements in their present condition, AS IS. State has made no oral or written representations concerning the condition of the Leasehold or its Improvements, if any, nor their fitness or suitability for any purpose.

3.4 Limitation on Improvements: Lessee may not construct or place upon the Leasehold any Improvement that exceeds $15,000 in cost or value unless Lessee has first obtained the prior written authorization of State or the Improvement is exempt under OAR 141-082-0300. State shall not unreasonably withhold or delay its approval for Improvements consistent with the purposes of this Lease. All Improvements must be consistent with the authorized use(s) of this Lease stated in Section 3.1 and in compliance with all applicable laws, regulations, and ordinances as stated in Section 3.2.1.

3.5 Disposition of Unauthorized Improvements or Structures: Lessee shall remove all unauthorized Improvements from the Leasehold upon receiving Notice from State, unless State elects to remove the Improvements at Lessee's cost and expense.

3.6 Removal of Authorized Improvements: Lessee shall remove all authorized Improvements within 90 days after the termination or expiration of the Lease or

modification of the Lease under Section 4.2, unless otherwise agreed by the parties or the Improvement is exempt under OAR 141-082-0310. Lessee is responsible for any damage done to the Leasehold as a result of the removal of any Improvement. Any Improvement remaining on the Leasehold after the 90 days will at the option of State become the property of State, unless otherwise agreed by the parties.

3.7 Liability: Lessee shall defend, indemnify and hold State harmless from and against all claims, demands, actions, suits, judgment, losses, damages, penalties, fines, costs, and expenses (including expert witness fees and costs and attorney's fees in an administrative proceeding, at trial, or on appeal) arising from or attributable, in whole or in part, to the Lease or any operations conducted or allowed by Lessee on the Leasehold. As used in this Section 3.7 only, "State" means the State of Oregon and its boards, commissions, agencies, officers, employees, contractors, and agents.

3.8 Waste Water Disposal: In addition to any other applicable laws and regulations, Lessee shall obtain any permits required by state or local authorities and shall comply with Oregon Department of Environmental Quality and Oregon State Marine Board requirements for sewage collection and waste water disposal for boats and floating structures.

3.9 Hazardous Substances:

3.9.1 Lessee shall not use, store, or dispose of, or allow the use, storage, or disposal within the Leasehold of any material that may pose a threat to human health or the environment, including without limitation, hazardous substances, pesticides, herbicides, or petroleum products (a "Hazardous Substance") except in strict compliance with applicable laws, regulations and manufacturer's instructions, and Lessee shall take all necessary precautions to protect human health and the environment and to prevent the release of any Hazardous Substance on or from the Leasehold.

3.9.2 Lessee shall keep and maintain accurate and complete records of the amount of all Hazardous Substances stored or used on the Leasehold, and shall immediately notify State of any release or threatened release of any Hazardous Substance on or from the Leasehold or otherwise attributable to operations or activities on the Leasehold.

3.9.3 If any Hazardous Substance is released, and the release arises from or is attributable, in whole or in part, to any operations conducted or allowed by Lessee on the Leasehold, Lessee shall promptly and fully remediate the release in accordance with state and federal regulations and requirements. If Lessee fails to so remediate, State may remove and remediate any release of a Hazardous Substance on or from the Leasehold or attributable to operations or activities conducted or allowed by Lessee on the Leasehold and collect the cost of removal or remediation from Lessee either as additional Rent or as damages.

3.9.4 In addition to any duty to indemnify specified elsewhere in this Lease, Lessee shall indemnify State to the fullest extent allowed by Oregon law against

any claim or costs arising from or related to a release of a Hazardous Substance arising from or attributable, in whole or in part, to any operations conducted or allowed by Lessee on the Leasehold.

3.10 Weed Control: Lessee shall control plant pests and diseases and noxious weeds, including aquatic weeds, within the Leasehold as directed by the local county weed control district, the Oregon Department of Agriculture or any other governmental authority which has authority for the prevention or control, or both, of noxious weeds, plant pests or diseases, or as may be authorized or directed by State.

SECTION 4 - MODIFICATION OF LEASEHOLD AREA OR USE

4.1 Change of Leasehold Area or Use: Lessee may request that State amend the Lease to expand or reduce the size, or change the authorized use, of the Leasehold using a form provided by State. However, no such amendment will be effective unless authorized in writing by State. State shall process and review requests to amend the Lease in the same manner as a new lease application.

4.2 Special Conditions Applicable to Reductions in Leasehold Area. This Lease may be amended to reduce the Leasehold area only if the portion of the Leasehold to be removed from the Lease does not contain any Improvement. If the amendment results in a reduction of Rent due under the Lease, the reduction will be effective commencing on the Lease Anniversary Date that falls at least 12 months after the later of: (a) the date of the reduction in the Leasehold area; or (b) the date on which the amendment is fully executed.

4.3 Lessee Liable for Violations. Notwithstanding any reduction in the Leasehold area under this section, Lessee shall remain liable for any violation of Section 3.8 or 3.9 occurring on lands removed from the Leasehold prior to the amendment removing such lands.

SECTION 5 – RESERVATIONS

5.1 Access: State reserves a right of access to the Leasehold, which, subject to any applicable provisions of the Oregon Residential Landlord and Tenant Act, ORS chapter 90, the State may exercise at all reasonable times to inspect and manage the State's interest in the Leasehold and to evaluate and ensure compliance with the terms and conditions of this Lease. State may examine pertinent records of Lessee for the purpose of ensuring compliance with the Lease.

5.2 Minerals: State reserves all rights to coal, oil, gas, geothermal resources and other minerals, and all deposits of clay, stone, gravel and sand valuable for building, mining, or commercial purposes including, without limitation, the right to explore, mine, develop, produce and remove such minerals and other deposits, along with the right of ingress and egress for these purposes, and to terminate this Lease as to all or any portion of the Leasehold when required for these purposes with 120 days prior written notice to Lessee or as otherwise provided by law.

5.3 Easements: State reserves the right at any time to grant easements across the Leasehold for tunnels, telephone and fiber optic cable lines, pipelines, power lines, or other lawful purpose, along with the right of ingress and egress for these purposes, subject to the inclusion in any such grant of easement of a requirement that the easement holder take all reasonable precautions to ensure that exercise of their easement rights does not unreasonably interfere with Lessee's use(s) authorized in the Lease.

5.4 Public Access and Recreational Use: All state-owned submerged and submersible land must remain available and open to the public for commerce, navigation, fishing and recreation unless restricted or closed by State to public entry pursuant to the provisions of applicable Oregon Administrative Rules. Lessee may request State, but State is not obligated, to close the Leasehold to public entry or restrict recreational use by the public on all or portions of the Leasehold to protect persons or property from harm arising from or in connection with Lessee's activities.

This reservation does not grant the public any right to use or occupy, without Lessee's permission, Lessee-owned property or structures authorized under this Lease.

5.5 Other: State reserves all other rights not expressly granted to Lessee under this Lease.

SECTION 6 – ASSIGNMENTS; SUBLEASES

6.1 Assignment and Sublease:

6.1.1 Except as provided in Section 6.2, Lessee may not assign this Lease or sublease the Leasehold or any portion of the Leasehold nor enter into any third party agreement respecting the Lease or the Leasehold without first obtaining the prior written consent of State pursuant to the requirements of the applicable Oregon Administrative Rules. Requests must be in writing using an application form prescribed by State. The application must be received by State at least 30 calendar days prior to the proposed effective date of the sublease or assignment. State shall make a good faith effort to complete its review of Lessee's application within 30 days following receipt. If the application is incomplete, or if State requests additional information concerning the proposed assignment or sublease, the time period for reviewing applications may be extended and the proposed sublease or assignment may be delayed pending the completion of such review.

6.1.2 State reserves the right to condition its consent to an assignment or sublease as State deems reasonably prudent, including the right to require changes to the terms of this Lease. Each assignee, sublessee, and third party interest will be required to comply with all of Lessee's obligations under this Lease, and the applicable Oregon Administrative Rules. Lessee will remain liable for the performance of all obligations under this Lease unless State's written consent expressly releases Lessee from further liability.

6.1.3 For the purposes of this section, if Lessee is a corporation or partnership or limited liability company, the transfer of any corporate stock or

partnership or membership interest (including by operation of law) will be deemed an assignment subject to the provisions of this section if the result of the transfer is a change of management control or controlling interest in Lessee.

6.1.4 Lessee may not grant a mortgage or security interest in this Lease without prior written consent of State, which consent shall not be unreasonably withheld. Any subsequent assignment by the creditor will require the prior written approval of State.

6.2 Permitted Assignments and Subleases: Notwithstanding Section 6.1 of this Lease, the following assignments, mortgages and security interests, and subleases of Lessee's interest in the Leasehold are permitted and written notice to State is not required:

6.2.1 subleases of portions of Lessee's interest in the Leasehold area in the ordinary course of Lessee's business for the purposes approved under Section 3.1;

6.2.2 the sublease of the entire Leasehold for a term that is less than one year for a purpose specified in Section 3.1; or

6.2.3 the transfer of Lessee's interest in the Lease to a surviving spouse or immediate family member following the death of Lessee; except that, any other transfer of ownership following the death of Lessee is considered an assignment requiring State's approval.

SECTION 7 – DEFAULT

7.1 Default: The following are events of default:

7.1.1 Failure of Lessee to pay any rent, tax, reimbursement or other charge or payment due under the Lease within 20 days after the date payment is due. For the purposes of this subsection, if the due date for payment is not otherwise stated in this Lease or otherwise defined in statute or administrative rule, payment is due on the date set forth in the Notice from State to Lessee informing Lessee of its obligation to pay the charge or payment.

7.1.2 Failure of Lessee to comply with any non-payment-related term or condition or obligation of the Lease within 30 days after Notice by State specifying the nature of the deficiency, or, in the event of an emergency, within the time specified by State to resolve the emergency. Upon timely request from Lessee, State may in its good faith discretion permit the deadline for curing non-compliance to be extended if it finds that: (1) the default cannot reasonably be cured within the 30 day period; (2) the interests of State will not be harmed by an extension; (3) default was not due to the willful act or gross negligence of Lessee; and (4) State and Lessee mutually agree upon a written plan and timeline for curing the non-compliance.

7.1.3 Any of the following:

a) insolvency of Lessee;
b) the filing by Lessee of a voluntary petition in bankruptcy;
c) an adjudication that Lessee is bankrupt or the appointment of a receiver of the properties of Lessee;
d) the filing of any involuntary petition of bankruptcy and failure of Lessee to secure a dismissal of the petition within 30 days after filing; or
e) attachment of or the levying of execution on the Leasehold interest and failure of Lessee to secure discharge of the attachment or release of the levy of execution within ten days.

If Lessee consists of two or more individuals or business entities, the events of default specified in this paragraph apply to each individual or entity unless within ten days after an event of default occurs the remaining individuals or entities produce evidence satisfactory to State that they have unconditionally acquired the interest of the one causing the default. If the Lease has been assigned under Section 6 of this Lease, the events of default specified in this subsection apply only with respect to the one then exercising the rights of Lessee under the Lease.

7.1.4 Notwithstanding the above, if State in good faith believes that a material default has occurred which may imperil State's rights in the land or the discharge of its Constitutional obligations with respect to the land, State may declare an immediate default without any right of Lessee to cure the deficiency.

7.2 Termination of Occupancy Upon Default: State may terminate Lessee's right to occupy the Leasehold for any default by Lessee that remains uncured past the time provided in Section 7.1. State shall exercise its right to terminate Lessee's occupancy under this section by providing Notice to Lessee of the default and of State's intent to terminate Lessee's right of occupancy under the Lease upon the date provided in the Notice. State may recover from Lessee all costs arising out of State's re-entry and, if State and Lessee mutually agree to terminate the Lease as provided in Section 1.4, all costs of re-letting the Leasehold. If State and Lessee mutually agree to terminate the Lease, State may recover the amount of unpaid rent that otherwise would have been required to be paid under the Lease from the date of default until a new Lease has been secured or, if State and Lessee do not agree to terminate the Lease and State is unable to secure another lessee for the Leasehold, until such time as the Lease expires. Lessee shall dispose of all Improvements as specified in Section 3.6 of this Lease. If Lessee owns a floating home and has placed the home on the Leasehold pursuant to the provisions of Section 3.1 of this Lease, the lease termination provisions of ORS chapter 90 will apply to the extent the provisions of this Lease are inconsistent with this chapter.

7.3 State's Right to Cure Defaults:

7.3.1 If Lessee fails to perform any obligation under this Lease, State may perform the obligation of the Lease 30 days after providing Notice to Lessee. All of State's expenditures to carry out the obligation must be reimbursed by Lessee on demand with interest at the rate of one percent per month accrued from the date of expenditure by State.

7.3.2 Notwithstanding Section 7.3.1, but subject to ORS chapter 90 if applicable, if any violation of a term or condition of this Lease, including without limitation use of the Leasehold in a manner not permitted under the Lease, is causing or threatens to cause personal injury or damage to the Leasehold or other property, or if damage to the Leasehold arises from some other cause, State may immediately enter upon the Leasehold and take such action as it deems necessary to stop the use or mitigate the injury or damage. If the injury or damage is due to a violation of the terms or conditions of this Lease, Lessee will be liable for all costs incurred by State as a result of the violation and the action taken by State to mitigate the injury or damage. State, at its option, may send Notice to Lessee of the violation and, upon receipt of the Notice, Lessee shall immediately cease the violation and repair the injury or correct all damage caused by the violation. State's failure to provide Notice of a violation may not be deemed a waiver of the violation by State or authorization to Lessee to continue or fail to correct the violation.

SECTION 8 – INSURANCE; BONDS

8.1 LESSEE shall maintain during the term of this License, the required insurance coverages described in attached Exhibit B.

8.2 Bond: State reserves the right to require Lessee to furnish to State a surety bond or an equivalent cash deposit or certificate of deposit, in an amount to be determined by State in the exercise of its reasonable discretion, which names the State of Oregon as co-owner to ensure that Lessee will perform in accordance with all terms and conditions of the Lease.

SECTION 9 - ADDITIONAL CONDITIONS AND STIPULATIONS

9.1 N/A

SECTION 10 - MISCELLANEOUS

10.1 Entire agreement: This Lease, together with the attached exhibits and attachments, constitutes the entire agreement between the parties. No waiver, consent, modification or change of terms of this Lease will bind either party unless in writing. Such waiver, consent, modification or change, if made, will be effective only in the specific instance and for the specific purpose given, and will be valid and binding only if it is signed by each party. There are no understandings, agreements or representations, oral or written, not specified herein regarding this Lease. This Lease supersedes all prior or existing lease or rental agreements between the parties with respect to the Leasehold described in this Lease.

10.2 No Partnership: State is not a partner nor in a joint venture with Lessee in connection with any business carried on in connection with this Lease or the Leasehold and has no obligation for Lessee's debts or other liabilities.

10.3 Non-Waiver: Waiver by either party of strict performance of any provisions of this Lease will not be a waiver nor prejudice the party's right to require strict performance of the same provision in the future or of any other provision.

10.4 Notices:

10.4.1 Any communication required by the terms of this Lease to be given in writing (hereafter, a "Notice") must be given or be served by:

a) depositing the same in the United States mail, postage prepaid; registered or certified mail, with return receipt requested; or
b) personal delivery service with all charges billed to shipper; or
c) expedited delivery service with all charges billed to shipper; or
d) prepaid telegram, telex or facsimile;

addressed to the party for whom the Notice is intended at the address set forth below or at such other address as the party may designate from time to time.

For Notices to Tenant:

Clackamas County Parks,
Attn: Rick Gruen, Parks Manager
150 Beavercreek Rd., Suite 419
Oregon City, OR 97045

For Notices to Landlord:

Department of State Lands
775 Summer Street NE, Suite 100
Salem, OR 97301-1279

10.4.2 Notice is deemed received:

a) upon receipt if sent by telegram, telex or facsimile or if personally delivered (as long as delivery is confirmed by the receiving telex or facsimile operator, including electronic confirmation of receipt, or by the courier delivery service, as the case may be); or
b) three business days after the date of deposit in a post office or other official depository under the care and custody of the United States Postal Service, if sent by United States mail; or
c) on the date of delivery by any expedited delivery service, or
d) on the date any party declines to accept any Notice given as provided in this section.

10.4.3 Each party shall have an address, for Notice purposes, that is within the continental United States and, if any party resides outside the continental United States, the party shall designate an agent for the purpose of receiving Notices whose address is within the continental United States. Any party may change its address for the purpose of receiving Notices by delivering a Notice of the change of address to the other party as described in this section 7.3.

10.4.4 Communications between the parties that are not required by this Lease to be in writing may be by any mutually acceptable method.

10.5 Governing Law; Venue: This Lease and all matters related to the rights and responsibilities of the parties under it are governed by and subject to the laws of the State of Oregon and the administrative rules of the Department of State Lands and the State Land Board, as they may change from time to time. The Oregon Administrative Rules contain terms and conditions which relate to the rights and responsibilities of the parties under this Lease, and all such terms and conditions (as they may change from time to time) are hereby incorporated by reference and made a part of this Lease. Any claim, action, suit or proceeding (collectively, a "Claim") between State and Lessee that arises from or relates to the Lease must be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; except that, if a Claim must be brought in a federal forum, then unless otherwise prohibited by law it must be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. However, in no way is this section or any other provision of this Lease to be construed as a waiver by the State of Oregon of any form of defense or immunity, whether it is 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. Lessee, by execution of this Lease, hereby consents to the personal jurisdiction of all such courts.

10.6 Binding on Successors: This Lease is binding on and will inure to the benefit of the successors and assigns of the parties to it, but nothing in this section may be construed as a consent by State to any disposition or transfer of the Lease or any interest in it by Lessee except as otherwise expressly provided in this Lease.

10.7 Nondiscrimination: The Leasehold must be used in a manner, and for such purposes, that assure fair and nondiscriminatory treatment of all persons without respect to race, creed, color, religion, handicap, disability, age, gender, or national origin.

10.8 Right To Sue More Than Once: State may sue periodically to recover damages accrued to date and no action for damages will bar later actions for damages subsequently accruing.

10.9 Remedies Cumulative: The remedies contained in this Lease are in addition to, and do not exclude, any other remedy available at law or in equity, and the exercise by either party of any one or more of its remedies does not preclude the exercise by it at the same or different times of any other remedies for the same default or breach by the other party.

10.10 Attorney Fees: If suit or action is instituted in connection with any controversy arising out of or in connection with this Lease, the prevailing party is entitled to recover all costs and disbursements incurred, including such sums as the court may adjudge reasonable as attorney fees at trial and on any appeal of the suit or action, and in any bankruptcy case or proceedings. State's obligation under this section is subject to the limitations of Article XI, section 7 of the Oregon Constitution.

10.11 Exhibits: All Exhibits to which reference is made in this Lease are incorporated in this Lease by the respective references to them, whether or not they are actually attached. References to "this Lease" include matters incorporated by reference.

10.12 Survival. Termination or expiration of the Lease will not extinguish or prejudice State's right to enforce the provisions of this Lease relating to indemnification, access to records, governing law, venue and consent to jurisdiction.

Lessee, by the signature below of its authorized representative, hereby acknowledges that Lessee has read this Lease, understands it and agrees to be bound by its terms and conditions.

STATE:
The State of Oregon, acting by
and through the Oregon State
Land Board and the
Department of State Lands
775 Summer ST NE, STE 100
Salem, OR 97301-1279

Lori Warner Dickason
DSL Authorized Signature/
Printed Name

8.28.14
Date

LESSEE:

Clackamas County Parks
Political Subdivision
150 Beavercreek Rd., Suite 419
Oregon City, OR 97045

Manager
Signature/Title

(Note requirement below)
8/12-14
Date

Note: If Lessee is a corporation, partnership, limited liability company or other form of business entity, signer warrants that s/he has the authority to sign the Lease on behalf of such entity by resolution of its Board of Directors or equivalent, or through delegation of authority to the signer.

OFFICIAL SEAL
LISA DIANNE MEURS
NOTARY PUBLIC-OREGON
COMMISSION NO. 468993
MY COMMISSION EXPIRES JUNE 05, 2016

STATE OF Oregon)
)ss
County of Clackamas)

The foregoing instrument was acknowledged before me this 12th day of August, 2014, by Rick Gruen
(name of officer or agent of political entity)
the Manager of Clackamas County Parks,
(title of officer or agent) (name of political entity)

Lisa Meurs
Signature
My commission expires 6/5/16

CERTIFICATE OF COMPLIANCE WITH OREGON TAX LAWS

By signature on this Lease for Lessee, the undersigned hereby certifies under penalty of perjury that the undersigned is authorized to act on behalf of Lessee and that Lessee is, to the best of the undersigned's knowledge, not in violation of any Oregon Tax Laws. For purposes of this certification, "Oregon Tax Laws" means a state tax imposed by ORS 320.005 to 320.150 (Amusement Device Taxes), 403.200 to 403.250 (Tax For Emergency Communications), 118 (Inheritance Tax), 314 (Income Tax), 316 (Personal Income Tax), 317 (Corporation Excise Tax), 318 (Corporation Income Tax), 321 (Timber and Forest Land Taxation) and 323 (Cigarettes And Tobacco Products) and the elderly rental assistance program under ORS 310.630 to 310.706 and any local taxes administered by the Department of Revenue under ORS 305.620.

Signature: _____

Date: 9-12-14

Printed Name: Rick Green

Title: Manager

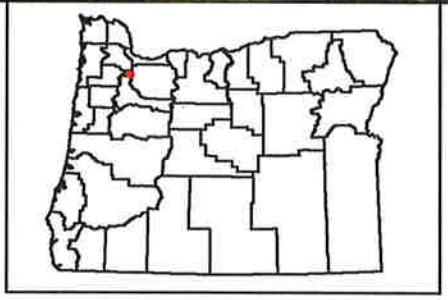
Oregon Department of State Lands
Land Management Division

N
W E
S

0 60 120
Feet

1 inch = 131 feet

Map Projection:
Oregon Statewide Lambert
Datum NAD83
International Feet



Vicinity Map

Legend

Legal Description

This map depicts the approximate location and extent of a Deptartment of State Lands, Land Management Division authorization for use and/ or property transaction. This product is for informational purposes only and may not have been prepared for, or be suitable for legal, engineering, or surveying purposes. Users of this information should review or consult the primary data and information sources to ascertain the usability of the information.

Exhibit A

Contact:
State of Oregon
Department of State Lands
Land Management Division
503-986-5309
www.oregon.gov/dsl/LW

Date: 6/27/2014

Software: ESRI ArcMap 10.0
Document Path: O:\GIS Projects\MyAuthorizations\MXDs\Scratch Pad Map 10.2.mxd

Exhibit B
INSURANCE REQUIREMENTS

During the term of the Lease Lessee shall maintain in force at its own expense, each insurance noted below:
(State must check boxes for #2, #3, #4, #5 and #6 to indicate whether insurance is required or not.)

1. **Required by State of lessee with one or more workers, as defined by ORS 656.027.**
Workers' Compensation. All employers, including Lessee, 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). Lessee shall require and ensure that each of its sublessees (if permitted) complies with these requirements.

2. ☐ **Required by State** ☒ **Not required by State.**
Professional Liability coverage, insuring against claims for damages caused by error, omission or negligent acts related to professional services to be provided under this Lease. Lessee shall provide proof of insurance of not less than the following amounts:

☐ $_____
or
☐ Amounts not less than the amounts listed in the following schedule:

Per occurrence limit for any single claimant:
From commencement of the Lease term to June 30, 2015: $2,000,000.
July 1, 2015 and thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 3 (Senate Bill 311).

Per occurrence limit for multiple claimants:
From commencement of the Lease term to June 30, 2015: $4,000,000.
July 1, 2015 and thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 3 (Senate Bill 311).

3. ☒ **Required by State** ☐ **Not required by State.**
General Liability coverage, insuring against claims for bodily injury, death and property damage. Coverage must include contractual liability coverage for the indemnity provided under this Lease. **The commercial general liability insurance coverages required under this Lease must include the State of Oregon, and its agencies, departments, divisions, commissions, branches, officers, employees, and agents as additional insureds. See Number 9 below.**
Lessee shall provide proof of liability or commercial general liability insurance in not less than the following amounts:

Bodily Injury/Death:
☒$1,000,000.00 combined single limit per occurrence
☒$2,000,000.00 aggregate limit for all claims per occurrence
or
☐ Amounts not less than the amounts listed in the following schedule:
Per occurrence limit for any single claimant:
From commencement of the Lease term to June 30, 2015: $2,000,000.
July 1, 2015 and thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 3 (Senate Bill 311).

Per occurrence limit for multiple claimants:
From commencement of the Lease term to June 30, 2015: $4,000,000.
July 1, 2015 and thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 3 (Senate Bill 311).

Property Damage:
☒$100,000.00
or
☐ Amounts not less than the amounts listed in the following schedule:
Per occurrence limit for any single claimant:
From commencement of the Contract term to June 30, 2015: $109,400.
From July 1, 2015, and every year thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 5 (Senate Bill 311).

Per occurrence limit for multiple claimants:
From commencement of the Contract term to June 30, 2015: $546.800.
From July 1, 2015, and every year thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 5 (Senate Bill 311).

4. ☐ **Required by State** ☒ **Not required by State.**
Automobile Liability coverage, insuring against claims for bodily injury and property damage, including coverage for owned, hired or non-owned vehicles, as applicable. **The automobile liability insurance coverages required under this Lease must include the State of Oregon, and its agencies, departments, divisions, commissions, branches, officers, employees, and agents as additional insureds. See Number 9 below.** Lessee shall provide proof of insurance of not less than the following amounts:

Bodily Injury/Death:
☐$_____ combined single limit per occurrence
☐$_____ aggregate limit for all claims per occurrence
or
☐ Amounts not less than the amounts listed in the following schedule:
Per occurrence limit for any single claimant:
From commencement of the Lease term to June 30, 2015: $2,000,000.
July 1, 2015 and thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 3 (Senate Bill 311).

Per occurrence limit for multiple claimants:
From commencement of the Lease term to June 30, 2015: $4,000,000.
July 1, 2015 and thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 3 (Senate Bill 311).

Property Damage:
☐$_____
or
☐ Amounts not less than the amounts listed in the following schedule:
Per occurrence limit for any single claimant:
From commencement of the Contract term to June 30, 2015: $109,400
From July 1, 2015, and every year thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 5 (Senate Bill 311).

Per occurrence limit for multiple claimants:
From commencement of the Contract term to June 30, 2014: $546,800.
From July 1, 2015, and every year thereafter the adjusted limitation as determined by the State Court Administrator pursuant to Oregon Laws 2009, chapter 67, section 5 (Senate Bill 311).

5. ☐ **Required by State** ☒ **Not required by State.**
Marine Protection and Indemnity Coverage. Lessee shall obtain, at Lessee's expense, and keep in effect during the term of the Lease, marine protection and indemnity coverage. Shall not be less than $_____.

6. ☒ **Required by State** ☐ **Not required by State.**
Pollution Liability: Lessee shall obtain at Lessee's expense, and shall keep in effect during the term of the Lease, pollution liability insurance covering Lessee's liability for bodily injury, property damage and environmental damage resulting from sudden accidental and gradual pollution and related cleanup costs incurred by Lessee, all arising out of Lessee's lease of the Leasehold. Shall not be less than $100,000.00.

7. **"Tail" Coverage.** If any of the required liability insurance is on a "claims made" basis, Lessee 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 Lease, for a minimum of 24 months following the termination or expiration of the Lease.

8. **Certificates of Insurance.** As evidence of the insurance coverages required by this Lease, the Lessee shall furnish acceptable insurance certificates to State prior to commencing any work to be performed under the Lease. The certificate must specify all of the parties who are additional insureds. If requested, complete copies of insurance policies, trust agreements, etc. shall be provided to State. Lessee shall pay for all deductibles, self-insured retention and self-insurance.

9. **Additional Insured.** The commercial general liability and automobile liability insurance coverages required under this Lease must include the State of Oregon, and its agencies, departments, divisions, commissions, branches, officers, employees, and agents as additional insureds but only with respect to Lessee's activities to be performed under this Lease. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

CLACKAMAS COUNTY

BUSINESS & COMMUNITY SERVICES
150 BEAVERCREEK ROAD
OREGON CITY, OR 97045
WWW.CLACKAMAS.US/BCS
LAURA ZENTNER, DIRECTOR

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Contract with Janz Enterprises, Inc. for the
Carver Boat Launch Parking Lot Curb Replacement and Asphalt Overlay

Purpose/Outcomes	This Contract will resurface the Carver boat launch and site curbing along with its adjacent sidewalks.
Dollar Amount and Fiscal Impact	Contract value is $231,098.00
Funding Source	213-7641-06606-485150-64077 Department funds
Duration	Contract execution through June 1, 2020
Previous Board Action	None
Strategic Plan Alignment	This project will provide strong infrastructure and ensure safe communities by maintaining the County's existing road infrastructure. This project will further reduce the backlog of deferred maintenance projects in County Parks
Counsel Approval	April 7, 2020
Contact Person	Rick Gruen, 503-742-4345

Background:
Work will consist of replacing a substantial amount of the Carver boat launch site curbing and adjacent sidewalks. Work also will include a subsequent resurfacing of the boat launch main parking lot and the boat launch loop with modified C hot mix asphalt ("HMAC").

The main parking lot and the launch loop will receive a nominal 2-inch lift asphalt overlay. Some required per-leveling in one identified low area and a 2-inch linear patch paving along the face of the replacement curbs is also required. Approximately 2260 feet of former extruded perimeter and island curbing had failed due to age and abuse. Additionally, approximately 580 feet of former curb in contact with a curb tight sidewalk running along the north perimeter required an upgrade. All of these curbs and mentioned sidewalk were previously removed following a neat asphalt saw cut line and now need to be replaced with Type "C" curb set 1 foot from the asphalt saw cut line. Excavation and reuse of the existing underlying aggregate base is included in this work in order to form and cast the new "C" curbs having a 7" exposure subsequent to the overlay resembling the pre-existing curb alignment at the slightly raised elevation. 320 feet of new 5-foot wide curb tight sidewalk running along the north side from the ADA parking then westerly to the boat ramp requires reconstruction.

The project work is anticipated to begin immediately following contract signing. Substantial completion will be not later than June 1, 2020, with final completion no later than June 30, 2020.

Procurement Process:
This project was advertised in accordance with ORS and LCRB Rules on February 19, 2020. Bids were opened on March 19, 2020. The County received ten (10) bids: Berrien Concrete, LLC., $336,487.00; D&D Concrete and Utilities, Inc., $277,200.00; MJ Hughes, $372,065.00; Hals Construction, $348,146.00; Eagle-Elsner, Inc., $241,680.00; North Santiam Paving Co, $284,980.00; Knife River Corporation, $281,355.00; Janz Enterprises, Inc, $222,388.00; 3 Kings Environmental, Inc., $266,478.00; and Brix Paving Northwest, $305,20.00. After review of the bids, Janz Enterprises, Inc. was determined to be lowest responsive bidder.

Bidders were asked to submit alternates to their bids which included Alternate #1: South Side Curb Replacement and Alternate #2: Eastward Sidewalk Extension. Upon accepting Janz Enterprises bid, the department opted to accept bid Alternate #2 at an increase of $8,710.00. Total contract value inclusive of Alternate #2 will be $231,098.00.

Recommendation:
Staff respectfully recommends that the Board approve and sign this public improvements contract with Janz Enterprises, Inc. for the Carver Boat Launch Parking Curb Replacement and Asphalt Overlay.

Sincerely,

Laura Zentner,
BCS Director

Placed on the BCC Agenda _____ by Procurement

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT
Contract #2563

This Public Improvement Contract (the "Contract"), is made by and between the Clackamas County, a political subdivision of the State of Oregon, hereinafter called "Owner," and **Janz Enterprises, 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: **#2020-20 Carver Boat Launch Parking Lot Curb Replacement and Asphalt Overlay**

1. Contract Price, Contract Documents and Work.
The Contractor, in consideration of the sum of **two hundred thirty-one thousand ninety-eight Dollars ($231,098.00)** (the "Contract Price"), to be paid to the Contractor by Owner in the manner and at the time hereinafter provided, and subject to the terms and conditions provided for in the Instructions to Bidders and other Contract Documents (as defined in the 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 Work includes the Carver Boat Launch Curb Replacement and Asphalt Overlay as well as the Eastward Sidewalk Extension. The Contract Price is the amount contemplated by the Base Bid plus Alternate #2 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
- Instructions to Bidders
- Bid Bond
- Public Improvement Contract Form
- Clackamas County General Conditions
- Prevailing Wage Rates

2. Representatives.
Contractor has named John Sayles 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 Rick Gruen as its Authorized Representative in the administration of this Contract. The above-named individual shall be the initial point of contact for matters related to Contract performance, payment, authorization, and to carry out the responsibilities of the Owner.

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

3. Key Persons.
The Contractor's personnel identified below shall be considered Key Persons and shall not be replaced during the project without the written permission of Owner, which shall not be unreasonably withheld. If the Contractor intends to substitute personnel, a request must be given to Owner at least 30 days prior to the intended time of substitution. When replacements have been approved by Owner, the Contractor shall provide a transition period of at least 10 working days during which the original and replacement personnel shall be working on the project concurrently. Once a replacement for any of these staff members is authorized, further replacement shall not occur without the written permission of Owner. The Contractor's project staff shall consist of the following personnel:

Project Executive: John Sayles shall be the Contractor's project executive, and will provide oversight and guidance throughout the project term.

Project Manager: John Sayles shall be the Contractor's project manager and will participate in all meetings throughout the project term.

Job Superintendent: John Sayles shall be the Contractor's on-site job superintendent throughout the project term.

4. Contract Dates.
COMMENCEMENT DATE: Upon Issuance of Notice to Proceed ("NTP")
SUBSTANTIAL COMPLETION DATE: June 1, 2020
FINAL COMPLETION DATE: 120 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 as an additional insured. Insurance certificates may be returned with the signed Contract or may be emailed to Procurement@clackamas.us.

6. 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.

7. Confidential Information.
Contractor acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Contract, be exposed to or acquire information that is confidential to Owner. Any and all information of any form obtained by Contractor or its employees or agents in the performance of this Contract shall be deemed confidential information of Owner ("Confidential Information"). Contractor agrees to hold Confidential Information in strict confidence, using at least the same degree of care that Contractor uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third

parties or use Confidential Information for any purpose unless specifically authorized in writing under this Contract.

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

10. Integration.
All provisions of state law required to be part of this Contract, whether listed in the General or Special Conditions or otherwise, are hereby integrated and adopted herein. Contractor acknowledges the obligations thereunder and that failure to comply with such terms is a material breach of this Contract.

The Contract Documents constitute the entire agreement between the parties. There are no other understandings, agreements or representations, oral or written, not specified herein regarding this Contract. Contractor, by the signature below of its authorized representative, hereby acknowledges that it has read this Contract, understands it, and agrees to be bound by its terms and conditions.

11. Liquidated Damages
The Contractor acknowledges that the Owner will sustain damages as a result of the Contractor's failure to substantially complete the Project in accordance with the Contract Documents. These damages may include, but are not limited to delays in completion, use of the Project, and costs associated with Contract administration and use of temporary facilities.

11.1 Liquidated Damages shall be as follows if the actual Substantial Completion exceeds the required date of Substantial Completion:
11.1.1. $300 per Calendar day past the Substantial Completion date.

12. Compliance with Applicable Law. Contractor shall comply with all federal, state, county, and local laws, ordinances, and regulations applicable to the Work to be done under this Contract including, but not limited to, compliance with the prohibitions set forth in ORS 652.220, compliance of which is a material element of this Contract and failure to comply is a material breach that entitles County to exercise any rights and remedies available under this Contract including, but not limited to, termination for default.

13. 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.

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:
Janz Enterprises, Inc.
P.O. Box 127
Boring, Oregon 97009

Contractor CCB #204540 Expiration Date: 11/4/2020
Oregon Business Registry #1051227-90 Entity Type: DBC State of Formation: Oregon

Signature page to follow.

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.

Janz Enterprises, Inc.	Clackamas County Board of County Commissioners
_____	_____
Authorized Signature Date	Chair Date
_____	_____
Name / Title Printed	Recording Secretary
	APPROVED AS TO FORM
	_____
	County Counsel Date