January 2020

Doing the Right Thing Right

Our Code of Conduct

Culture of Diversity and Respect

We adhere to all laws and regulations and are committed to a workplace culture where all individuals are treated with respect and dignity, regardless of protected characteristics, as defined by local, state, or federal law, including but not limited to race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), genetic information, marital status, age, sex (which includes pregnancy, childbirth, breastfeeding and related medical conditions), gender, gender identity, gender expression, sexual orientation, and military and veteran status.

Quality of Care and Patient Safety

We commit to provide the best, *compassionate* care and service every time and strive to meet and exceed national standards for quality and patient *safety*.

Stewardship of Resources

We commit to effective stewardship of resources in support of patient care and organizational goals and only use resources for legitimate business purposes.

Conflicts of Interest (COI) Commitment

We will avoid actual or perceived COI and agree to disclose any outside interests or activities, contracts, and relationships that may be in conflict to the organization. We maintain impartial relationships with vendors, research sponsors, and contracts by not requesting or accepting gifts, cash, or cash equivalents.

Ethical and Legal Standards

We conduct ourselves in a professional and ethical manner in support of *justice* and will perform our job duties in accordance with all federal, state, and local laws.

Our mission, vision, values, and promise provide guidance and inspiration as we deliver quality care, make sound, ethical choices, and meet our organizational goals. As workforce members, we are accountable for the integrity of our decisions and actions on the job. The Code of Conduct provides a foundation of expectations for us as we do our work each day.

Ways to report a concern

- *Discuss the matter or concern with your immediate supervisor*
- *Discuss the matter or concern with your department leader*
- *Discuss with your HR Partner, HR Service Center, or send report via HR Portal*
- *Contact your local or regional compliance or privacy representative*
- *Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option.*
- *For Caregivers in India:*
  - From an outside line, dial the direct access number: 000-117
  - At the English prompt dial 888-294-8455

You may report concerns anonymously

Safeguarding Patient Information and Protecting Privacy and Confidentiality

We take every precaution to safeguard patient information, and we will treat protected health information (PHI) of all with special care and follow all federal, state, and local laws.

Ethical Conduct of Research

We follow the highest ethical standards and comply with all laws, regulations, guidelines, and ethical directives (where applicable) that govern human, animal, and basic applied science research.

Licensure and Certification

We require all health care and education professionals to follow all federal, state, and local laws applicable to licensing, credentialing, and certification requirements. Individuals on the excluded provider lists cannot work for our organization.

Compliance with Applicable Federal and State Laws and Regulations, and Policies

We ensure *excellence* by requiring all parties that work for or on behalf of an employer within our family of organizations learn and follow all laws, regulations, and policies.

Fair Business Practices

We conduct ourselves ethically, honestly, and with *integrity* at all times.

Reporting Violations and Protection from Retaliation

We will use the appropriate method to report any violation or suspected violations of our code(s), fraud, waste, or abuse as required. Retaliation or harassment will not be tolerated.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 per person / $900 per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, most preventive care, emergency and urgent care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500 per person / $7,500 per family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See ProvidenceHealthPlan.com/phs-employees or call 1-800-878-4445 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; deductible does not apply	Not covered	Some services such as lab and x-ray will include additional member costs. Phone and video visits are covered in full.
	Specialist visit	$40 copay/visit; deductible does not apply	Not covered	
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	Not all preventive services are required to be covered in full by the ACA. For more information on preventive services that are covered in full see: ProvidenceHealthPlan.com/PreventiveCare. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ProvidenceHealthPlan.com	Formulary generic drug	$10 copay retail $30 copay mail order	Not covered	Safe Harbor Preventive drugs are covered in full. ACA Preventive drugs are covered in full in-network. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay. *Certain specialty drugs are subject to the Smart RxAssist program and its rules: the list of specialty drugs subject to this program can be found at: providencehealthplan.com/phs-employees
	Non-formulary generic drug	$10 copay retail $30 copay mail order	Not covered	
	Formulary brand-name drug	20% coinsurance (max $75 per 30-day supply)	Not covered	
	Non-formulary brand-name drug	40% coinsurance (max $125 per 30-day supply)	Not covered	
	Specialty drug	Generic: 20% coinsurance* Brand-name: 20% coinsurance*	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. Other in-network facility fees not covered unless emergency.
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$250 copay; deductible does not apply	$250 copay; deductible does not apply	For emergency medical conditions only. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. If admitted to hospital, all services subject to inpatient benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$60 copay/visit; deductible does not apply	Not covered	Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. Other in-network facility fees not covered unless emergency.
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Provider visits: No charge; deductible does not apply All other services: 20% coinsurance	Not covered	Additional services available through the Caregiver Assistance Program. All services except provider office visits may require prior authorization. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Applied behavioral analysis	No charge; deductible does not apply	Not covered	
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office visits	No charge; deductible does not apply	Not covered	——————none——————
	Childbirth/delivery professional services	No charge; deductible does not apply	Not covered	——————none——————
	Childbirth/delivery facility services	20% coinsurance	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to 130 visits per calendar year.
	Rehabilitation services	Outpatient physical therapy: 20% coinsurance; deductible does not apply All other services: 20% coinsurance	Not covered	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 75 visits per calendar year. Limits do not apply to Mental Health Services.
	Habilitation services	20% coinsurance	Not covered	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 75 visits per calendar year. Limits do not apply to Mental Health Services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
	Skilled nursing care	20% coinsurance	Not covered	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. Coverage is limited to 60 days per calendar year.
	Durable medical equipment	Diabetes supplies: No charge; deductible does not apply. All other medical equipment: 20% coinsurance	Not covered	——————none——————
	Hospice services	No charge; deductible does not apply	No charge; deductible does not apply	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam and glasses (Child)
- Infertility treatments (Diagnostic testing and counseling of infertility are covered. Limits may apply.)
- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 12 visits combined with chiropractic care)
- Bariatric surgery
- Chiropractic care (limited to 12 visits combined with acupuncture)
- Hearing Aids (limited to $1,500 every 36 months)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or http://www.ProvidenceHealthPlan.com.
- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

This Summary of Benefits and Coverage required by the Affordable Care Act summarizes the benefit options available to eligible employees as of January 1, 2023. The official plan document and summary plan description will provide more complete details regarding the terms of the Plan. If there is any conflict between the statements in this Summary and the official plan documents, the terms of the plan documents will govern all rights and obligations of participants, beneficiaries, plan fiduciaries and the Company. Providence Health & Services reserves the right to amend or terminate these benefits or change the cost of coverage, for any reason, at any time.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,440**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$510
Coinsurance	$740
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,610**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$690**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement:

Providence Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan does 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 Services:

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 .بگیرید تماس 1-800-878-4445 (TTY: 711) با .باشد می ف

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)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com/phs-employees. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,150/per person $2,300/per family (2 or more) Out-of-Network: $2,300/per person $4,600/per family (2 or more).	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, most preventive care, emergency services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $3,300/per person $6,600/per family (2 or more) Out-of-Network: $6,600/per person $13,200/per family (2 or more).	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums; penalties; your costs for Supplemental Benefits; services not covered; balanced-billed charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of participating providers see Providence HealthPlan.com/phs-employees or call 1-800-878-4445.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO/Preferred Network (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/per in-person visit; deductible does not apply	$20 copay/per in-person visit; deductible does not apply	50% coinsurance	Some services such as lab and x-ray will include additional member costs.
	Specialist visit	10% coinsurance	20% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	50% coinsurance	For more information on preventive services that are covered in full see: ProvidenceHealthPlan.com/Preventive Care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Preventive drugs: Generic and Formulary Brand-name	No charge; deductible does not apply	No charge; deductible does not apply	Not covered	Formulary, Non-formulary brand name and Specialty drugs: max $150 coinsurance per 30-day supply per drug. Covers up to a 30-day supply (retail); 90-day supply (mail-order). Prior authorization may apply. If you do not obtain prior authorization claims for
	Generic drugs	$10 copay retail $30 copay mail order	$10 copay retail $30 copay mail order	Not covered	
	Formulary brand-name drugs	20% coinsurance retail and mail order	30% coinsurance retail and mail order	Not covered	
	Non-formulary brand-name drugs	40% coinsurance retail and mail order	50% coinsurance retail and mail order	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO/Preferred Network (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
www.providencehealthplan.com/phs-employees.	Specialty drug	20% coinsurance*	20% coinsurance*	Not covered	those services will be denied and you will be responsible for payment of those services. Specialty drugs can only be purchased at a participating specialty pharmacy. *Certain specialty drugs are subject to the Smart RxAssist program and its rules: the list of specialty drugs subject to this program can be found at: providencehealthplan.com/phs-employees
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	50% coinsurance or no coverage for some facilities	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
If you need immediate medical attention	Emergency room care	$250 copay; deductible does not apply	$250 copay; deductible does not apply	$250 copay; deductible does not apply	If admitted to hospital, copay not applied. All services subject to inpatient benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	To the nearest appropriate facility.
	Urgent care	10% coinsurance	20% coinsurance	50% coinsurance	Some services will incur additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO/Preferred Network (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Provider visits: No charge; deductible does not apply All other services: 10% coinsurance	Provider visits: No charge; deductible does not apply All other services: 20% coinsurance	50% coinsurance	Additional services available through the Caregiver Assistance Program. All services except provider office visits may require prior authorization. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Applied behavioral analysis	No charge; deductible does not apply	No charge; deductible does not apply	25% coinsurance	
	Inpatient services	10% coinsurance	25% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No charge; deductible does not apply	No charge; deductible does not apply	50% coinsurance	——————none——————
	Childbirth/delivery professional services	No charge; deductible does not apply	No charge; deductible does not apply	50% coinsurance	Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	50% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	50% coinsurance	Limited to 130 visits per calendar year.
	Rehabilitation services	10% coinsurance	Inpatient Services: 25% coinsurance Outpatient Services: 20% coinsurance	50% coinsurance	Outpatient: coverage limited to 75 visits per calendar year. Limits do not apply to Mental Health Services.
	Habilitation services	10% coinsurance	Inpatient Services: 25% coinsurance Outpatient Services: 20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO/Preferred Network (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	Diabetes supplies: No charge; deductible does not apply. Hearing aids: 10% coinsurance. All other medical equipment: 20% coinsurance	Diabetes supplies: No charge; deductible does not apply All other medical equipment: 20% coinsurance	50% coinsurance	——————none——————
	Hospice services	No charge	No charge	No charge	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	No coverage for vision services.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam and glasses (Child)
- Infertility treatments (Diagnostic testing and counseling of infertility are covered. Limits may apply.)
- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 12 visits combined with chiropractic care)
- Bariatric surgery
- Chiropractic care (limited to 12 visits combined with acupuncture)
- Hearing Aids (limited to $1,500 every 36 months)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or http://www.ProvidenceHealthPlan.com.
- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

This Summary of Benefits and Coverage required by the Affordable Care Act summarizes the benefit options available to eligible employees as of January 1, 2023. The official plan document and summary plan description will provide more complete details regarding the terms of the Plan. If there is any conflict between the statements in this Summary and the official plan documents, the terms of the plan documents will govern all rights and obligations of participants, beneficiaries, plan fiduciaries and the Company. Providence Health & Services reserves the right to amend or terminate these benefits or change the cost of coverage, for any reason, at any time.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,150
Specialist copayment	$20
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$850
Copayments	$0
Coinsurance	$2,450
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,150
Specialist copayment	$20
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,150
Copayments	$510
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,150
Specialist copayment	$20
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,150
Copayments	$60
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,570**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement:

Providence Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan:

- Provides 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)
- Provides 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 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
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 Services:

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 .بگیرید تماس 1-800-878-4445 (TTY: 711) با .باشد می ف

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)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com/phs-employees. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,500 for employee only coverage $3,000 for any level greater than employee only Out-of-Network: $3,000 for employee only coverage $6,000 for any level greater than employee only	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Most preventive care services in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $3,000 for employee only coverage $6,000 for any level greater than employee only Out-of-Network: $6,000 for employee only coverage $12,000 for any level greater than employee only	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums; penalties; your costs for Supplemental Benefits; services not covered; balanced-billed charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.providencehealthplan.com/phs-employees or call 1-800-878-4445 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO/Preferred Network (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	10% coinsurance	50% coinsurance	Some services such as lab and x-ray will include additional member costs.
	Specialist visit	10% coinsurance	20% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	50% coinsurance	For more information on preventive services that are covered in full see: ProvidenceHealthPlan.com/PreventiveCare You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.providencehealthplan.com/phs-employees	Preventive drugs: Generic and Formulary Brand Name	No charge; deductible does not apply	No charge; deductible does not apply	Not covered	Generic, Formulary, Non-formulary brand name and Specialty drugs: max $150 per 30-day supply per drug. Covers up to a 30-day supply (retail); 90-day supply (mail- order). Prior authorization may apply. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. Specialty drugs can only be purchased at a participating specialty pharmacy.
	Generic drugs	10% coinsurance	10% coinsurance	Not covered	
	Formulary brand-name drugs	20% coinsurance	30% coinsurance	Not covered	
	Non-formulary brand-name drugs	40% coinsurance	50% coinsurance	Not covered	
	Specialty drug	20% coinsurance	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO/Preferred Network (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	50% coinsurance or no coverage for some facilities	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	To the nearest appropriate facility.
	Urgent care	10% coinsurance	20% coinsurance	50% coinsurance	Some services will incur additional member cost.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Provider visits: No charge; all other services: 10% coinsurance	Provider visits: No charge; all other services: 20% coinsurance	50% coinsurance	Additional services available through the Caregiver Assistance Program. All services except provider office visits may require prior authorization. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Applied behavior analysis	No charge	No charge	25% coinsurance	
	Inpatient services	10% coinsurance	25% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No charge; deductible does not apply	No charge; deductible does not apply	50% coinsurance	——————none——————
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	50% coinsurance	Coinsurance applies to provider delivery charges.
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	Rehabilitation services	10% coinsurance	Inpatient Services: 25% coinsurance Outpatient Services: 20% coinsurance	50% coinsurance	Outpatient: coverage limited to 75 visits per calendar year. Limits do not apply to Mental Health Services
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	Skilled nursing care	20% coinsurance	20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
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If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-up.

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- Cosmetic surgery (with certain exceptions)
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- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- Weight loss programs

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- Acupuncture (limited to 12 visits combined with chiropractic care)
- Bariatric surgery
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*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,860**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,890**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement:

Providence Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan:

- Provides 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)
- Provides 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 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
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 Services:

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).

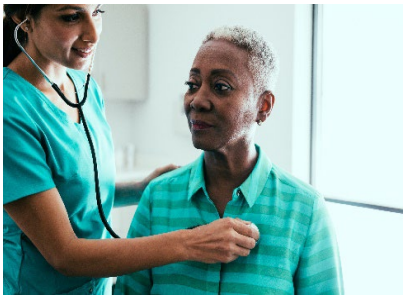
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید تماس 1-800-878-4445 (TTY: 711) با .باشد می ف

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)

Summary Plan Description



Effective: January 1, 2021

This Summary Plan Description is designed to provide general information about the Providence Health & Services Health and Welfare Plan (PN 501). The terms of your benefit plans are governed by plan documents. This summary may not include all plan rules and details. Providence Health & Services reserves the right to amend, modify or terminate any plan, in whole or in part, at any time for any reason.

In the event there is a discrepancy between information provided in guides, plan materials or website content and the information described in this Summary Plan Description, the contents in this document shall prevail.

Note: Summary Plan Descriptions are required to be updated every 5 years under ERISA.

The Summary Plan Description contains a summary in English of your plan rights and benefits under the Providence Health & Services Health and Welfare Plan (PN 501). If you have difficulty understanding any part of this Summary Plan Description, contact the Benefits Service Center at 888-615-6481, Monday – Friday from 7:30 a.m. to 6:00 p.m. Pacific time. Translation services are available in most languages upon request.

Para obtener asistencia en Español, llame al 888 – 615-6481.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-615-6481.

如果需要中文的帮助, 请拨打这个号码 888-615-6481.

Overview of Coverage

Every employee is unique, each with different needs and family situations. The Providence Health & Services Health and Welfare Plan ("Plan") is designed to meet the varying needs of the Providence Health & Services ("Providence") employees well into the future. As your personal situation changes from year to year, you may want to change some of your benefits elections. With the Providence Health & Services Health and Welfare Plan, you have the flexibility to meet these needs. You may make changes to your elections each year during ***Open Enrollment***, or during the year if you have a qualifying event (please review the **Eligibility and Enrollment** chapter for more information).

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this.***

What Are My Benefit Options?

For some benefits, you are automatically enrolled for coverage and Providence pays the entire cost of coverage. For others, you must make an election for coverage or waive coverage. All of your benefit options are listed on the ***HR Service Portal.***

As a benefits-eligible employee, you have the following benefits options available to you. Refer to the ***HR Service Portal*** for the costs and contributions that apply if enrolled.

Benefit	Options
Medical	• Up to four medical plans to choose from for you and your eligible dependents • No coverage (Waive)
Dental	• Up to three dental plans to choose from for you and your eligible dependents • No coverage (Waive)
Vision	• One vision plan for you and your eligible dependents • No coverage (Waive)
Caregiver Assistance Program	• Automatically enrolled in this coverage
Life Insurance	• Automatically enrolled in basic coverage • Supplemental coverage for you, your spouse/***Adult Benefits Recipient (ABR)*** and your dependent children
Accidental Death & Dismemberment (AD&D)*	• Voluntary coverage for you, your spouse and your dependent children
Short -Term Disability (STD)	• Supplemental coverage available
Long-Term Disability (LTD)	• Automatically enrolled in basic LTD coverage • Supplemental coverage available for you
Health Care *Flexible Spending Account* (FSA)	• Paycheck contributions to this account to pay for eligible out-of-pocket (deductible, copayments) medical, dental, or vision expenses on a ***pre-tax basis***

Benefit	Options
Dependent Care *Flexible Spending Account* (FSA)	• Paycheck contributions to this account to pay for eligible dependent care expenses on a ***pre-tax basis***

Some employees may have access to Basic AD&D; check the **HR Service Portal for additional information*

How Much Do I Have to Pay?

Providence Health & Services Contributions

Employer contributions represent a portion of the total premium associated with certain benefits. Providence provides this share of the cost to you for specific benefits, and you are responsible for paying the difference between the total cost of coverage and what Providence pays.

You are not taxed on Providence's contributions, with the exception of coverage for an Adult Benefits Recipient (ABR) and the eligible children of your ***ABR Partner***, and Basic Employee Life Insurance coverage over $50,000. For more information, please review the **Taxes and Your Benefits** section, below.

Employee Contributions

If the total plan cost of your benefits exceeds the amount Providence contributes, you will make up the difference through payroll deductions. Each benefit option has an associated cost for you, unless Providence is paying the full cost of coverage. Your coverage and the associated health benefits cost per pay period appear in the ***HR Service Portal***.

Taxes and Your Benefits

Some of your contributions are deducted from your pay before taxes are applied, and some are taken after taxes. If you elect coverage with ***pre-tax contributions***, you reduce your taxable income and pay less in taxes. This can increase your take-home pay.

Health Benefits

If you elect health coverage for yourself and your dependents, you generally pay for this coverage with ***pre-tax contributions***. Health coverage is subject to taxes for the following dependents, unless you can claim them on your federal tax return:

- ***Adult Benefits Recipients (ABR)***
- ***ABR Partners*** (domestic partners)
- Children of ***ABR Partners***

Your contributions toward this coverage are to be made with ***after-tax dollars*** and the portion of your ABR's coverage that Providence contributes on their behalf will be considered taxable income.

State laws vary on recognition of registered domestic partners, which can affect ***imputed income***. You are generally responsible for paying imputed income unless your ABR is also your federal tax dependent.

Please consult your tax advisor if you have questions.

Flexible Spending Accounts (FSAs)

You can pay for certain eligible health care or dependent care expenses with pre-tax dollars and further reduce your taxable income by participating in the Health Care FSA or the Dependent Care FSA. Please refer to the **Health Care FSA** chapter and the **Dependent Care FSA** chapter for additional information.

Life, AD&D, Short-Term and Long-Term Disability Benefits

If you elect Supplemental Life, Voluntary AD&D, Voluntary Short-Term and Long-Term Disability "buy-up" coverage, you pay for this coverage with ***after-tax contributions***. This means the premium is deducted from your pay after taxes are applied.

The value of your Basic Life Insurance provided by Providence above $50,000 is taxable. Please review the **Life and Accident Insurance** chapter for additional information.

Tax Laws Can Change

The tax advantages available under the Plan apply to federal taxes (income tax and Social Security tax), and generally apply to state and local income taxes, if applicable. These advantages are based on the federal and various state laws as they are written today and are subject to change in the future.

You should be aware that any reduction in your pay subject to Social Security taxes could lead to a reduction in your Social Security benefits. For most employees, the reduction in Social Security benefits will be insignificant in comparison to the value of paying lower taxes today.

Since tax laws vary from state to state, please consult your tax advisor for the implications of your elections.

Default Benefits if You Take No Enrollment Action

New Hire/Newly Eligible

If you are newly eligible for benefits and you do not enroll in benefits within 30 days from your date of hire or first day as a benefits-eligible employee, you will be assigned default benefits for yourself only. The default benefits may not reflect the best benefit choices for your particular situation.

Default benefits include the following:

- Life Insurance – Basic coverage
- Long-Term Disability Plan – Basic coverage

These benefit dollar amounts may be viewed on the ***HR Service Portal***.

The following benefit is automatically available to you regardless of your enrollment elections:

- Caregiver Assistance Program

You will **not** be enrolled in the following coverage:

- Medical, Dental and Vision for you or your dependents
- Supplemental Life and AD&D for you or your dependents
- Health Care Flexible Spending Account (FSA) or Dependent Care FSA*
- Short-Term Disability insurance (buy-up option)
- Long-Term Disability Insurance (buy-up option)

*As a newly hired employee, you are eligible to contribute to a Health Care Flexible Spending Account or the Dependent Care FSA. If you submit your elections on or after November 1, you are not eligible to

make FSA elections for the current year. You must wait until ***open enrollment*** to make changes for the following ***Plan Year***.

After default benefits become effective, changes can only be made during ***Open Enrollment*** or due to a qualifying family status change.

Please review the **Qualifying Events** section of the **Eligibility and Enrollment** chapter for additional information.

Annual Open Enrollment

The annual ***Open Enrollment*** period occurs each Fall giving you the opportunity to change your elections for the upcoming ***Plan Year***, which begins January 1. Unless otherwise announced, if you do not make changes to your current plan elections or to who you are covering during the specified Open Enrollment dates:

- If you currently have coverage, your existing Medical, Dental, Vision, Short-Term Disability, Long-Term Disability, Supplemental Life and Voluntary AD&D coverage will roll over automatically* to the next ***Plan Year*** at the corresponding Plan Year's full employee contribution rates.
- If you waive Medical coverage in the current year, and make no changes during ***Open Enrollment***, your waived coverage will carry over into the following year.
- If there has been a change in the options and your elected option is not offered, you will receive the designated replacement plan option and price, and your dependents as currently listed will be covered. This Plan will not necessarily be identical in coverage to your previous plan.
- Your participation in the Health Care FSA and Dependent Care FSA will **not** carry forward to the next Plan Year, as FSA's, per federal regulations, require an annual election. Refer to the **Flexible Spending Account** chapter for rollover provisions.

Annual re-enrollment is required for ACA (including per-diem/non-benefits eligible) employees who want coverage in the next **Plan Year at the full employer premium rates.*

Note: Review the annual *Open Enrollment* information to learn whether an active enrollment will be required for coverage or whether there is a change in the assigned default process for the new (upcoming) *Plan Year's* elections.

Following the close of the ***Open Enrollment*** period, changes can only be made during the next Open Enrollment or due to a qualifying family status change. Please review the **Qualifying Events** section of the **Eligibility and Enrollment** chapter for more information.

Changing Work Location

If you move from one Providence location to another, your coverage elections and enrolled dependents will generally carry over automatically. If your transfer results in you becoming ineligible for your current benefit options, you will receive an outreach email and can log in to the ***HR Service Portal*** to see if any benefit changes are available. You will have 30 days from the date of transfer to make your elections in the ***HR Service Portal***. If no elections are made during the enrollment period, you will be assigned default benefits.

You may have the opportunity to change your medical and dental coverage if you are moving from full-time to part-time status and your premium costs increase significantly. You will have 30 days from the date of the transfer to make your elections in the ***HR Service Portal***.

Following the close of your transfer change enrollment period, changes can only be made during ***Open Enrollment*** or due to a qualifying family status change. Please review the **Qualifying Events** section of the **Eligibility and Enrollment** chapter for additional information. If your transfer results in other

qualifying change in status events, those events will be processed under qualifying event rules and processes.

Rehire or Return to Benefits-Eligible Status

Return within 30 days

If you are rehired or return to a benefits-eligible status within 30 days of when you terminate or change to non-benefits-eligible status, your previous benefit elections will be reinstated. These elections will take effect on the date of your rehire or the date that you return to benefits-eligible status. If you were contributing to an FSA, your account will be recalculated to collect the annual election amount over the remaining pay periods in the calendar year. This will result in a larger deduction in your remaining paychecks.

Following your return, changes can only be made during ***Open Enrollment*** or due to a qualifying family status change. Please review the **Qualifying Events** section of the **Eligibility and Enrollment** chapter for more information. If your return results in other qualifying change in status events, those events will be processed under qualifying event rules and processes.

Return after 30 days or more

If you are rehired or return to benefits-eligible status 30 or more days after you terminate or change to non-benefits-eligible status, you will be considered a new hire and must make new elections within 30 days of your return date. The following may also apply:

- If you were contributing to an FSA, your per-pay-period amount will not resume. Health charges incurred during your termination period are not eligible for reimbursement unless you had COBRA coverage for your Health Care FSA.
- You will be required to complete a Statement of Health for supplemental life insurance coverage above the guarantee issue limits.
- If you were enrolled in Long-Term Disability coverage with benefits ending due to non-payment of premiums, your coverage will be reinstated without a Pre-Existing Condition Limitation if you return to active work within 12 weeks of the date active benefits ended.

No Assignment of Benefits and Rights

You or your dependent may not assign any benefits, payments or other rights arising under the Plan to any other person. Your rights and benefits under the Plan cannot be assigned, sold, transferred, or pledged by you or reached by your creditors or anyone else except under limited circumstances (for example, compliance with a Qualified Medical Child Support Order). Any attempted assignment or attachment will be void, unenforceable, and disregarded.

You or your dependent may direct the payment of Plan benefits to a health care provider in accordance with procedures established by the ***Claims Administrator.*** Electing to do so satisfies the Plan's obligations for payment of benefits. The direction to pay a health care provider will not cause such health care provider to become a beneficiary under the Plan or of any legal or equitable right to institute any court proceeding or to request or receive Plan documents under ***Employee Retirement Income Security Act (*****"ERISA"*****)***, as amended. The Plan prohibits you or your dependents from assigning your rights to bring suit under ERISA to a physician, other health care provider, individual or entity who accepts assignment of claims. Nothing in this Plan will be construed to make the Plan, ***Plan Administrator***, or other Employer liable to any third-party to whom you or your dependent may be liable for medical care, treatment or services.

About this Summary Plan Description

This Summary Plan Description is designed to provide detailed information about the Providence Health & Services Health and Welfare Plan and how it works as of January 1, 2021. The Summary Plan Description does not constitute an implied or expressed contract or guarantee of employment. If any conflicts arise between this summary and the Plan documents and contracts, the Plan documents and contracts as interpreted by the ***Plan Administrator*** and fiduciaries, including ***Claims Administrators*** acting on their behalf, will govern. Likewise, the Summary Plan Description, Plan documents and contracts will govern, as interpreted by the Plan Administrator and fiduciaries, in the event of conflict with benefit communication materials and forms.

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials.

After-Tax Dollars/After-Tax Contributions

Funds you authorize Providence to withhold from your pay after taxes are deducted.

Adult Benefits Recipient (ABR)

- An adult living with you for the past 12 months as their is/her principal place of residence (that means there is no other place of residence, even on a part-time basis), and who will continue to do so for the foreseeable future, AND
- A member of your family unit AND a member of your household with whom you share a close personal relationship (this does not include a renter, roommate or other person living in your home on a casual basis; this does include a parent, sibling or your child age 26 or older), AND
- At least 18 years of age and is not your employee (e.g. nanny) or your child under age 26, AND
- Does not have access to other medical coverage (group, Medicare or Tricare).

If the above criteria is met, an ABR may be covered under the medical, dental and vision plans. The children of your ABR are not eligible for coverage under the plans.

Adult Benefit Recipient Partner (ABR Partner)

- A person registered as your domestic partner in your state of residence, if recognized. If not recognized, your ABR Partner must live with you in a long-term committed “spouse-like” relationship as a member of your household/family unit. The partner has lived with you for at least 12 months and plans to do so for the foreseeable future. In addition:
    - — the partner is a same sex partner of any age (18 or over) or opposite sex partner where one of you is age 62 or over AND
    - — neither of you is married to anyone else, or in a state-registered domestic partnership with another person and are not blood relatives of a degree of closeness that would prohibit marriage in your state of residence.

If the above criteria is met, an ABR-Partner and an ABR's children may be covered under the medical, dental, vision, life and AD&D insurance plans.

Adult Benefit Recipient (ABR Health and/or Life)

- An individual who shares a committed relationship with you, is financially interdependent and meets the other ABR coverage criteria as defined above. Eligibility for this relationship does not include coverage for your parent, sibling or child age 26 or over.

An ABR-Health and/or Life may be covered under the medical, dental, vision, life, and AD&D insurance plans or may be eligible for life and AD&D insurance coverage only. An ABR Health and/or Life’s child is eligible for life and AD&D insurance coverage only.

Claims Administrator

A third party administrator or insurer designated by the plan administrator or its delegate to review and process claims for benefits under the Plan.

ERISA

The federal Employee Retirement Income Security Act of 1974, as amended, which governs plan administration, supervision and management.

Flexible Spending Accounts (FSAs)

The FSAs are designed to save taxes. You elect to fund the accounts at the beginning of the Plan Year through payroll deductions and then are reimbursed from your account for eligible expenses you incur during the Plan Year.

HR Service Portal

Electronic resource for benefits information available at **hrforcaregivers.org**. Health and Welfare benefit elections can be entered by selecting the *Benefits – enroll, review or update (BenefitConnect)* link on the homepage under **External Links**. Access to the Benefits Service Center for questions is also available by navigating to the **Request HR Help > Benefits > Benefits Questions**. Other HR tools and resource materials are available on the portal.

Imputed income

The value of employer-provided coverage that is subject to taxation for dependents who are not Internal Revenue Code Sec.152 tax dependents. The value of coverage is the full premium amount, less after tax payroll deductions. The taxable amount is shown on your pay stub and included on your W-2 statement.

For health coverage, Providence is required to calculate imputed income for the following dependents, unless you can claim them as dependents on your federal tax return. Because you will pay taxes on the value of coverage, your take-home pay will be impacted. This tax is in addition to any premium costs shown on your confirmation statements when making health coverage elections.

- Adult Benefits Recipient (ABR)
- ABR Health and/or Life
- ABR Partner
- Child(ren) of ABR Partner

For Basic Life Insurance, Providence is required to calculate imputed income for Basic employee coverage over $50,000 using an IRS rate table, based on your age and amount of coverage.

Medicare

A federal health insurance program for the elderly and disabled, consisting of hospital insurance (Part A), supplemental medical insurance (Part B), private health plan options (Plan C), and prescription drug benefits (Part D).

Open Enrollment

A defined time period when you and all other eligible employees are allowed to enroll yourself and/or your dependents for benefit coverage and make desired changes.

Plan Administrator

The Plan Administrator is the sole fiduciary of the Plan and has all discretionary authority and control over the operation and administration of the Plan. The Plan Administrator has the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, and unless there was an abuse of discretion, such discretionary determinations regarding plan terms and eligibility shall be binding upon all participants and upon the employers.

The Plan Administrator may choose to hire a consultant and/or contract administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner.

Plan Year

The 12-month period beginning January 1 and ending December 31.

Pre-tax contributions

Funds you authorize Providence withhold from your pay before taxes are deducted.

Eligibility and Enrollment

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this***

Who Is Eligible?

Eligibility for Employees

Providence employees with a payroll status of Full Time Equivalency of 0.5 or above are eligible for health and welfare benefits on the date of hire or the date they move to a benefits-eligible position.

Under the Affordable Care Act, medical coverage is offered to employees who are per-diem, temporary or part–time and working less than the minimum number of hours above to qualify for regular benefits, and eligible children. The medical plan offered is the HSA Medical Plan for which you pay the full cost. This coverage is not available to spouses. This coverage also does not qualify for medical premium assistance or health incentives.

No Dual Coverage

Health (Medical, Dental and Vision): If you and your spouse or ***ABR Partner*** or a parent and an adult child are both employed by Providence and eligible for benefits, each employee may enroll in the Plan as an employee or as a dependent of an existing employee. For example, the whole family unit may enroll under one employee, if the other employee waives coverage. Children whose parents are both Providence employees may be enrolled under only one parent's medical, dental and vision coverage. If you have a covered family member who becomes eligible for benefits due to their own employment status, you should both review your benefits to ensure there is no ***dual coverage***, and then make adjustments to cancel any duplicate coverage by logging on to the ***HR Service Portal*** within 30 days or calling the Benefits Service Center.

If enrollment is made for ***dual coverage***, claims will be paid under only one employee's plan benefits, payments made in error will be subject to recovery, and enrollment will be cancelled with no refund of premium contributions paid for the dependent coverage. If health incentive funds were issued for an employee covered as a dependent, those funds should be returned to Providence.

Before changing any coverage, the Benefits Service Center will attempt to contact the involved employees to discuss available enrollment options. If the Benefits Service Center does not receive a response from the employees by the requested deadline, or the employees cannot agree, the ***Plan Administrator*** will maintain coverage for the children under the employee's plan who has covered them the longest, and remove children from the other employee's coverage. If there is a Qualified Medical Child Support Order (QMCSO), your employer is responsible for abiding by the terms of the order. In the case of dual employed/covered adults, the ***Plan Administrator*** will maintain separate coverage under each employee's enrollment record. It is your responsibility to notify the Benefits Service Center if you discover duplicate coverage.

For Life and AD&D Insurance – You may cover yourself and your spouse or ***ABR Partner and your ABR Health and/or Life***; if you both work for Providence. For coverage for your dependent child, see text box.

Eligibility for Dependents

Your dependents may also be eligible to participate.

Eligible dependents:

Spouse

A person to whom you are legally married under the law of any jurisdiction with the authority to sanction marriage, as recognized by the Internal Revenue Service, and any related federal guidance.

Life/AD&D: If you and your adult child are both benefits-eligible employees, your adult child is no longer eligible for coverage under your Dependent Life Insurance plan. Life insurance coverage is available through the adult child employee's insurance plan only**.**

If enrollment is made for dual coverage, enrollment will be cancelled with no refund of premiums paid for Dependent Life Insurance and claims will be paid under the adult child employee's life insurance plan only.

Civil Union/Common-Law Spouse

If you live in a state that recognizes a civil union or common-law spouse under the laws of the state, you may cover your civil union/common-law spouse under the Plan as a spouse, by providing a declaration of the relationship, and submitting a copy of the recent federal tax return showing filing as married filing jointly or married filing separately.

Adult Benefits Recipient (ABR)

Under certain circumstances, you may enroll an ***Adult Benefits Recipient (ABR)*** for coverage. The benefits available to your ABR depend on your relationship to each other. The benefits enrollment system will determine if your ABR is an eligible dependent under the Plan based on your responses to questions..

Providence defines an ***Adult Benefits Recipient*** as an individual who meets all of the following conditions:

- At least 18 years of age, and is not your employee (e.g. nanny) or child under age 26; AND
- Living with you for the past 12 months as their principal place of residence (that means there is no other place of residence, even on a part-time basis), and who will continue to do so for the foreseeable future; AND
- A member of your family unit and a member of your household with whom you share a close personal relationship (e.g., parent, sibling or your child age 26 or older); AND
- Does not have access to other medical coverage (group, Medicare, Tricare)

An ABR who meets these conditions is eligible for medical, dental, vision and Caregiver Assistance Program benefits. Children or legal dependents of your ABR are not eligible for benefits coverage.

Adult Benefits Recipient (ABR Health and/or Life)

This relationship subcategory includes an individual who meets the conditions above as an ABR, who shares a committed, financially interdependent relationship with you. Eligibility for this relationship does not include coverage for your parent, sibling or child age 26 or over. Your ABR Health and/or Life is eligible for medical, dental, vision, Caregiver Assistance Program benefits, dependent life, or dependent AD&D. The children or legal dependents of your ABR are not eligible for medical, dental or vision coverage and are eligible for life and AD&D insurance coverage.

In addition, the following criteria apply to coverage of ***Adult Benefits Recipients***:

- Coverage is limited to a maximum of two adults per household, including you.
- A different adult dependent cannot be covered under the various plans. For example, if an Adult Benefits Recipient is covered under your medical plan, a legal spouse cannot be covered under your dental plan.
- If two adult members of your household both work for Providence, you cannot add an Adult Benefits Recipient.
- If you enroll your adult child as your Adult Benefits Recipient at the time he or she reaches age 26 and is no longer eligible to be enrolled as a child, the cost of coverage will not be taxable to you for federal tax purposes for the remainder of the calendar year in which the child reaches age 26

Adult Benefits Recipient Partner (ABR Partner)

Expanded ABR Eligibility for Domestic Partners

An eligible ***ABR Partner*** may enroll for benefits if the following conditions are met:

- You and your ***ABR Partner*** sign a declaration attesting to your partnership, AND
- You have registered your domestic partnership if you live in a state with a registration process (i.e. Washington, Oregon or California), OR
- You meet similar plan criteria if you live in a state that has no registration/certification process (i.e. Alaska, Montana, Oregon or New Mexico for opposite sex, with one adult age 62 and over). This criteria follows:
  - Same sex partners of any age, or opposite sex partners where one adult is age 62 or over, AND
  - An adult living with you for the past 12 months in a long-term committed “spouse-like” relationship and who will continue to do so for the upcoming year and/or foreseeable future, AND
  - Must be age 18 or older, and not be your employee or child under age 26, AND
  - A member of your household/family unit, AND
  - Neither of you is married to anyone else, or in a state-registered domestic partnership with any other person, AND
  - You are both capable of consenting to this domestic partnership, AND
  - Partners must not be blood relatives of a degree of closeness that would prohibit marriage in the state of residence

You are eligible to cover your ABR Partner if…			
State of Residence	**You and your partner are the same sex, and both are 18 or older and meet other state requirements.**	**You and your partner are opposite sex and one of you is age 62 or older.**	**Depending on state, you may or may not be required to register / certify your relationship.**
Alaska	X	X	No state registration is available
California	X	X	Must be registered with the state
Montana	X	X	No state registration available
New Mexico	X	X	No state registration available.
Oregon	X	X	If same sex, registration with the state is required, if opposite sex, age 62 or older, no state registration is available
Washington	ABR Partner coverage is not available	X	Must be registered with the state
Other states	If you live in a state that is not identified above, contact the Benefits Service Center for additional information on eligibility.		

If your ***ABR Partner*** meets the requirements outlined above, a registered partner with your state of residence or if you live in a state that does not recognize domestic partnership, he/she is eligible for medical, dental, vision, Caregiver Assistance Program, dependent life and dependent AD&D. You may also cover your eligible ***ABR Partner's*** children in benefits under the Plan.

A completed declaration will need to be filed after enrollment of your ***Adult Benefits Recipient*** as part of the ***Plan's*** dependent eligibility verification process.

Note: Health coverage for an ABR is subject to taxes, unless you can claim them on your federal tax return. Your contributions toward this coverage are made with after-tax dollars and the portion of your ABR's coverage that Providence contributes on their behalf will be considered taxable income. State laws vary on recognition of registered domestic partners, which can affect imputed income. You are generally responsible for paying *imputed income* unless your ABR is also your federal tax dependent.

Children

An eligible child includes your:

- natural children, step-children, adopted children
- children for whom you are the legal guardian by court order
- foster children while you have legal responsibility as a foster parent, and
- unmarried children of your ***ABR Partner or ABR Health and/or Life (life/AD&D insurance only)***

If you or your eligible dependent child, spouse, or ABR (whether covered under this ***Plan*** or not) give birth to a child conceived and carried through a surrogacy agreement, he/she is not an eligible dependent under the Plan.

If your child does not live with you, is not supported by you, or is married, you may still enroll him or her as a child under your medical, dental, vision, Child Life and/or Child AD&D coverage until the child reaches age 26.

For children for whom you are the legal guardian – a dependent remains eligible only until the expiration date stipulated by the court within the Letters of Guardianship and generally does not extend beyond the dependent's age of emancipation, typically age 18. Foster children are eligible until you no longer have legal responsibility as a foster parent, generally up to age 18.

Married children of ***ABRs*** are not eligible for coverage under the Plan.

Qualified medical expenses may be reimbursed through the Health Care ***Flexible Spending Account, Health Savings Account and Health Reimbursement Account,*** for eligible children who are under age 27 as of the end of the calendar year, and tax dependents, even if the child is not an eligible dependent for health coverage purposes.

Coverage for Disabled Child

Health and life insurance coverage of a dependent child may be available past age 26 if he or she is incapable of self-support because of developmental, mental or physical disability and is your tax dependent under IRS Code Section 152. Contact the Benefits Service Center for more information. If approved by the ***Claims Administrator***, regular and ongoing verification of your disabled dependent's condition is required; failure to provide this will result in a loss of coverage.

Qualified Medical Child Support Orders (QMCSOs)

Federal law requires employer group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, a QMCSO is a judgment, decree, or order from a state court or state administrative agency that requires a parent to provide medical support to a child.

A QMCSO may require the employer group health plan to make health, dental, and/or vision coverage available for your child even though, for income tax or plan purposes, the child is not your dependent due to divorce or legal separation. In order to qualify as a QMCSO, the medical support order must:

1. Specify your last known name and address, and the child's name and last known address unless the order otherwise provides the name and mailing address of an official of a state or political subdivision thereof in place of the name and address of the child
2. Provide a reasonable description of the type of coverage to be provided by the plan or the manner in which the type of coverage is to be determined
3. State the period to which it applies, and
4. Specify each plan to which it applies.

The QMCSO may not require the group health plan to provide coverage for any type or form of benefit or any option not otherwise provided under the terms of the ***Plan***. You may be required to change your elected medical plan to comply with the QMCSO.

You and/or the child may be enrolled as required by the order, whether or not you consent. You must pay for coverage through payroll deductions or direct bill, as required by the order.

The ***Plan Administrator*** shall permit any child who is the subject of a QMCSO to designate a representative for receipt of copies of notices that are sent to the child with respect to a QMCSO. You and the affected child will be notified if an order is received. A child covered under the group health plan pursuant to a QMCSO will be treated as an eligible dependent.

Any payment for benefits made under the group health plan pursuant to a QMCSO for expenses paid by the child or the child's custodial parent or legal guardian shall be made to the child or the child's custodial

parent or legal guardian, if so specified. Participants and beneficiaries can obtain, at no charge, a copy of the plan's QMCSO procedures from the ***Plan Administrator***.

If you have a support order or dissolution of marriage decree that provides for coverage of a child on an employer group health plan, but which does not meet the criteria of a QMCSO, you may submit such for consideration of coverage of the child.

An order from a state agency addressed to an employer other than Providence to enforce the provisions of a medical support order, judgment or decree by requiring enrollment of specified children under that employer's plan is not a qualifying event for a mid-year change to add the children for coverage. Consideration for a qualifying event may be given if the person named in the underlying QMCSO is a Providence employee.

If you are covering a child under a QMCSO, your employer may drop the child from coverage only if your status changes and you no longer meet the requirements of the order, or your employer receives an updated order from the state agency to rescind the QMCSO.

Dependent Verification

The ***Plan*** reserves the right to request documentation to verify the eligible relationship of those you have enrolled as dependents at the time of enrollment or at a later time. Documentation includes but is not limited to:

- Birth certificates
- Court orders
- Marriage certificates
- Other declarations or affidavits
- Proof of shared address (for ***ABRs***)
- State declarations
- Tax returns

For a new dependent, you will be prompted to provide the required documentation within a specified time frame following enrollment. You may also be asked to verify dependent eligibility for currently enrolled dependents. If you do not provide the required documentation by the deadline, or if the documentation does not provide sufficient evidence of meeting the eligibility requirements of the ***Plan***, coverage for your dependent will be terminated on the last day of the month that you fail to meet the deadline. If the dependent verification process identifies a misrepresentation of the qualified change in status, coverage will be cancelled.

If you reenroll that individual under the ***Plan*** as a dependent, you will again need to provide documentation of the eligible relationship. If there is fraud or material misrepresentation by you, coverage may be cancelled retroactive to the date of ineligibility. You will have appeal rights under the Rescission of Coverage rules of the Patient Protection and Affordable Care Act.

When Can I Enroll or Change My Elections?

Initial Enrollment

When you first become eligible for benefits, you must enroll within 30 days of hire date or the date upon which you become benefits eligible as recorded in the HR payroll system.

Depending on when your event date is entered in the HR system, you may have less than 30 days to complete your enrollment but are still subject to the deadline to enroll; you will be provided with at least fourteen calendar days to make your elections. **Note, once you have submitted your elections, your**

enrollment period closes, and you will not be able to make additional changes during the initial enrollment period.

You may elect coverage for yourself or your eligible dependents during your initial enrollment period. If you elect Supplemental Employee Life Insurance or Dependent Life Insurance for your spouse (***ABR Health and/or Life or ABR Partner)***, a Statement of Health may be required before this coverage will take effect. Please review the **Life and Accident Insurance** chapter for more information. A Statement of Health is not required for dependent life insurance.

Action Required

You must take action to elect benefits within 30 days of hire or upon becoming benefits eligible. If you don't enroll, you will have basic life, and long-term disability insurance coverage for yourself only (no dependents will be covered). **You will not have medical, dental or vision coverage**. Please review the **Default Benefits if You Take No Enrollment Action** section in the **Overview of Coverage** chapter for more information.

Open Enrollment

You may also enroll or change coverage for yourself or your eligible dependents during the annual ***Open Enrollment*** period. Changes elected during Open Enrollment take effect the next ***Plan Year***, which begins January 1.

It is important that you read all the benefits information available to you on the ***HR Service Portal***, and any home mailing, if applicable, as this is how the ***Plan Administrator*** informs you of what is changing and what actions are needed to make the elections you want. Some standing instructions for ***Open Enrollment*** are:

- If you waive coverage in the current year, and make no changes during ***Open Enrollment***, your waived coverage(s) will carry over into the following year.
- If you want to contribute to the Health Care or Dependent Care FSA, you must make that election annually. Please review the **Health Care Flexible Spending Account** chapter and the **Dependent Care Flexible Spending Account** chapter for more information.
- If you are electing to add or to increase Supplemental Life Insurance for yourself, your spouse or your ***ABR***, you may be required to submit a Statement of Health for insurance approval. Please review the **Life and Accident Insurance** chapter for more information.

Action Required

If you newly enroll a dependent, you must respond to a dependent verification by the communicated deadline, or your dependent's coverage will end. Please review the **Dependent Verification** section for more information.

Please note: Health coverage (for the full premium amount) is offered to employees who are per-diem, temporary or part-time and working less than the minimum number of hours to qualify for regular benefits, and eligible children. Enrollment is required each year during *Open Enrollment*. If no election is made coverage ends on Dec. 31 of the prior year.

Please review the **How Do I Enroll or Change My Elections** section for more information about how to submit your elections during ***Open Enrollment***.

Qualifying Events

You can make certain benefit changes outside of ***Open Enrollment*** if you have a qualifying event, including special enrollments and other events. You may request an enrollment change with each qualifying change in status events you experience during the ***Plan Year***.

The benefit changes must be on account of, and correspond with a change in status that affects eligibility for coverage under the program, as required by Federal law and plan provisions. The Plan requires that you add yourself and/or your dependents to your coverage via the enrollment tool on the ***HR Service Portal*** or via the Benefits Service Center. You must also provide the documentation required for your specific event, as described on the portal at the time of enrollment.

Any material omission or misrepresentation in answering the questions in the enrollment tool may result in the denial of benefits, termination of coverage and enrollment for you and your dependents and/or disciplinary action including and up to termination of employment. The ***Plan Administrator*** reserves the right to request appropriate and/or legal documentation reflecting proof of status changes.

Special Enrollments

Under the Health Insurance Portability and Accountability Act (HIPAA), you may change your health coverage, including medical, dental or vision, as a result of these special enrollment events:

1. Birth, adoption or placement for adoption
2. Marriage
3. Loss of other group health insurance coverage for yourself or your eligible dependents due to loss of eligibility
4. Medicaid/CHIP events

Note: In the event of birth, adoption, placement for adoption or marriage, other dependents may be eligible for coverage under the "tag-along" rule. See below.

You must log on to the ***HR Service Portal*** and make a request to change your elections within 30 days of the qualifying event, or within 60 days for birth, placement for adoption, adoption or Medicaid/CHIP events. If you miss this window, you will have to wait until ***Open Enrollment***, when you can update all your elections for the next ***Plan Year***.

If you experience a special enrollment event, you may be eligible to make the following health care-related changes:

- Add, change or delete medical, vision or dental coverage for yourself or your eligible dependents (You must enroll yourself for coverage in order to add your eligible dependents.) Due to the "tag-along" rule, some events may allow you to add the affected dependent(s) and other eligible dependents who are not covered under the Plan at the time of the event.
- Begin or increase contributions to a FSA. Marriage, birth of a child, adoption/placement for adoption, legal guardianship of a child, judgment/decree/court order for coverage of a child are events that may allow you to enroll in or increase your FSA election.
- Loss of eligibility for group coverage for the employee, spouse or dependent and ineligibility for ***Medicare*** also allow for enrollment or increases in coverage.

Once your application for coverage as a special enrollment is accepted, you are responsible for any additional contributions required. You may also request a change in your existing medical plan as part of your HIPAA Special Enrollment rights; however, there are restrictions on transferring claims history between plans.

Birth, Adoption or Placement for Adoption

In the event of a birth or adoption, you have 60 days to enroll your newly born or adopted child from the date of birth, adoption or date of placement in your home for adoption. **Coverage is not automatic.**

Please visit the **How Do I Enroll or Change My Elections** section for additional information.

If you or your other dependents are benefits-eligible and were not previously covered under the Providence plan, you may enroll for that coverage along with enrolling your newly born or adopted child, as long as you do so within the 60-day time period.

Coverage and benefits premiums will be retroactive to the date of birth, adoption or placement. Legal date of placement is documented through either a state agency, a fully licensed adoption agency or applicable court order.

Marriage

In the event of marriage, you have 30 days from the date of marriage to enroll your new spouse.

If you or your other dependents are benefits-eligible and are not covered, you may enroll yourself and the additional dependents in coverage along with your new spouse.

Coverage and benefits premiums will be retroactive to the date of the event. This means that if your marriage occurs on February 20, and you submit your enrollment change on March 4, your spouse's benefit coverage will actually begin on the date of marriage – February 20 – and you will be responsible for any retroactive benefits premiums. **Note: Divorce, beginning a registered domestic partnership, and ending a registered domestic partnership are covered under Other Events**.

Loss of Other Health Insurance Coverage

If you waive Providence health coverage for yourself or your eligible dependents because you have other coverage, and then lose the other coverage due to one of the following, you may elect Providence health coverage for yourself and your eligible dependents:

- You and your spouse divorce, legally separate or annul your marriage
- Your spouse becomes eligible for ***Medicare***, creating a loss of coverage for you and/or your eligible dependents
- Your spouse or other eligible dependent loses coverage due to termination of employment, loss of benefits eligible status, disability, or death and can no longer cover you and/or them
- Your spouse's or other eligible dependent's employer's active benefits contributions end[1]
- You have exhausted all your COBRA coverage from another group plan (This does not mean an end to your previous employer's subsidized COBRA coverage, but an exhaustion of the entire COBRA period)

You have 30 days from these events to request a coverage change. Coverage and benefits premiums will be retroactive to the date of the event creating the loss of health coverage.

Medicaid/CHIP Events

If you waive Providence health coverage for yourself or your eligible dependents, you may enroll for medical coverage if you, your spouse and/or your dependents:

- Lose coverage under a state Medicaid or children's health insurance program (CHIP)
- Become eligible for premium assistance under state Medicaid or CHIP

If you or your eligible dependents become eligible for Medicaid, you may terminate your Providence medical coverage.

[1] Employer COBRA subsidy payments ending are not an eligible event to allow for benefit changes at Providence (or for enrollment on the ACA marketplace).

You have 60 days from these events to request enrollment under a Providence medical plan. Coverage and benefits premiums will be retroactive and will begin on the date of the event.

Note: This does not apply to individual coverage which you may choose to purchase through the state or federal Health Insurance Marketplace.

Other Events

In addition to the special enrollment events described above, you may make limited benefit changes for yourself or your eligible dependents if you experience any of the following events. There is some duplication between the events that qualify for the special enrollment rights and these events.

- Marriage, divorce, legal separation, annulment, becoming eligible for ***ABR*** partnership coverage, ending a domestic partnership, death.
- Change in number of eligible child dependents due to:
  - Birth
  - Placement for or finalization of adoption
  - Acquiring stepchild by marriage
  - Attainment of the legally appointed guardianship for a dependent child
  - Receipt of a judgment, decree of court order requiring you to provide coverage for a dependent child
- Change in eligibility of a child dependent such as reaching their 26th birthday, or ceasing to meet eligibility as a disabled dependent
- The employer of your spouse/***ABR Partner*** has a ***Plan Year*** which results in a different ***Open Enrollment*** period than Providence.
- Your enrolled dependent under age 26 moves out of the country (coverage is not available under the plans except for emergency care so this may qualify for a change in your health coverage election.)
- Change in your employment status from full-time to part-time which results in the amount of your medical and dental premium contribution increasing by 15% or more (this scenario would allow for you to change your medical and/or dental election to a lower cost plan option with Providence or to waive coverage.)
- Change in employment status of employee's spouse or enrolled dependent from full-time to part-time or from part-time to full-time or any other change in employment status (i.e., termination, change in worksite) that results in the gain or loss of eligibility for an employee or dependent. (If the employment status change does not result in a change in eligible coverage, no change in elections is allowed.)
- Transfer to a work location or change in home residence and the medical option or dental option in which you are currently enrolled is not available in your new location (this scenario would allow you to make a change to your medical or dental plan election.)
- Transfer to a worksite location that results in the amount of your medical and dental premium contribution increasing by 15% or more (this scenario would allow for you to change your medical and/or dental election to a lower cost plan option with Providence or to waive coverage.)
- Commencement of, or loss of, ***Medicare*** or Medicaid coverage on you or your spouse and dependents
- You participate in the Dependent Care FSA, and your child reaches the limiting age (13) during the year, or their eligibility otherwise changes as a result of certain status changes listed above
- You participate in the Dependent Care FSA, if dependent care costs change, for example, an increase in rates by the provider or employee relocation forces higher/lower costs
- Significant change in insurance coverage or cost through your eligible dependent's employer
- A judgment decree or order requiring an election change on a dependent child, including a foster child, as a result of divorce, legal separation, an annulment, or a change in legal custody
- Adding a dependent, spouse or child who is not a United States (U.S.) citizen, national of the U.S., or resident of the U.S. on the date they become a U.S. citizen, national of the U.S. or a resident of the U.S.

You become eligible to enroll in coverage through the Health Insurance Marketplace during a special enrollment or open enrollment period. You may revoke your existing medical election with Providence for you and your covered dependents, if this corresponds with your intent to enroll in Marketplace coverage. Changes must be requested within 30 days of the event by entering your information on the ***HR Service Portal***.

If you experience one of the events listed above under "Other Events", you may make changes as outlined below. Your requested benefit changes must be on account of, and correspond with a change in status that affects eligibility for coverage under the program:

- Add or delete medical, vision or dental coverage for yourself
- Add or delete medical, vision or dental coverage for your eligible dependents
- Add or reduce Supplemental Employee Life Insurance coverage (for certain events)
- Add or delete Supplemental Dependent Life Insurance coverage (for certain events)
- Add or reduce Dependent AD&D coverage if you are currently enrolled (for certain events)

The following events may allow you to begin or increase your Health Care FSA election:

- Marriage
- Birth of a child
- Adoption/placement for adoption
- Legal guardianship of a child
- Judgment/decree/court order for coverage of a child
- Loss of eligibility for group coverage for the employee, spouse or dependent
- Ineligibility for ***Medicare***

The following events may allow you to decrease the amount of your Health Care FSA election or end participation.

- Divorce
- Legal separation
- Annulment
- Death of a dependent

You are required to end coverage for the following dependents within 30 days of the event:

- A dependent who no longer meets the eligibility requirements or dies
- A spouse and their dependent children, if you divorce or legally separate
- An ***ABR***, if the qualifying criteria are no longer met
- An ***ABR*** and any eligible dependents, if the qualifying relationship ends

Former spouses/***ABRs*** are not eligible for coverage and no benefits will be paid on behalf of a former spouse/ABR who dies, even if you have continued to cover him or her under the ***Plan***.

Health coverage will terminate at the end of the month in which the event occurs unless continuation of coverage through COBRA is offered, elected and costs paid. If you notify the Benefits Service Center more than 30 days after the status change, or the ineligibility is otherwise identified, the ineligible person will be removed from coverage accordingly, effective on the nearest date needed to apply all plan rules and tax regulations, but no refund of premium will be available.

How Do I Enroll or Change My Elections?

You will be provided with information on the ***HR Service Portal*** describing your benefit options and instructions on how to enroll on the HR Service Portal. The benefits you elect will stay fixed for the ***Plan***

Year January 1 through December 31 (or the remainder of the Plan Year if you make mid-year elections), unless you experience a qualifying event, as described in the **When Can I Enroll or Change My Elections** section.

Initial Enrollment

Contributions, benefit options and plan information are located on the ***HR Service Portal***.

You must take action to elect benefits within 30 days of hire or upon becoming benefits-eligible. The 30 days window begins on the date of the event, rather than the date it is entered into the HR system.

To enroll, click the **Enroll, review or update benefits** button on the home page of the ***HR Service Portal***. If you want dependent coverage, you must also enroll your eligible dependents and link them to coverage at this time. (Simply adding your dependents information does not enroll them). **Coverage for dependents is not automatic**.

You must make your elections and then submit your choices. Once you have submitted your elections on the ***HR Service Portal***, your enrollment window closes, and you will not be able to make any additional changes. Print out a copy of your confirmation statement. If you report an enrollment error, this will be the requested documentation.

Action Required

You must take action to elect benefits within 30 days of hire or upon becoming benefits eligible. If you don't enroll, you will have basic life and disability insurance coverage for yourself only (no dependents will be covered). You will not have medical, dental or vision coverage. Please review the **Default Benefits If You Take No Enrollment Action** section in the **Overview of Coverage** chapter for more information.

Open Enrollment

You will be offered the opportunity to review your participation in the benefit plans, and select or change the dependents you are covering under each of the available plans, on an annual basis each Fall.

Information about the benefits for the next ***Plan Year*** and the enrollment tool are available on the ***HR Service Portal***. Any changes made during the defined ***Open Enrollment*** period will be effective the beginning of the next Plan Year, which begins January 1.

Qualifying Events

In general, you may not change your elections during the ***Plan Year***. However, if you experience a qualifying event, you may change your elections for medical, dental and vision coverage, as well as your elections for Supplemental Life Insurance, AD&D, Long-Term Disability and, in limited circumstances, your elections for the FSAs.

If you experience a qualifying event, you must access the ***HR Service Portal***, using the **Enroll, review or update benefits** button, or call the Benefits Service Center to provide your information and submit election changes. Note: There is a limited 30-day enrollment period for requesting such changes, otherwise you will have to wait until next ***open enrollment*** (except for special circumstances noted below).

Note: For more information about qualifying events, please review the When Can I Enroll or Change My Elections section.

When Does Coverage Begin?

Initial Enrollment

Your benefits become effective as outlined in the **Eligibility for Employees** section. You must make your elections within 30 days of this date or you will not be enrolled in benefits other than employer-provided basic life and disability insurance for yourself only.

Open Enrollment

If you newly elect coverage or otherwise make changes to your benefits during an annual ***Open Enrollment*** period, your new elections will go into effect on the following January 1, if you:

- Are eligible for benefits
- Have completed the enrollment process during the specified enrollment period

Once the ***Open Enrollment*** period has closed, no new elections may be made for the ***Plan Year***, unless you have a qualifying change in status event.

Special Enrollments

For special enrollments and qualifying family status changes, new elections are effective as follows:

Event	Election Period	Effective Date
Birth, adoption, placement for adoption	Up to 60 days from the date of the event to enroll for coverage	As of the date of birth, adoption, placement for adoption
Eligibility for Medicaid or state premium assistance	Up to 60 days from becoming eligible to enroll for coverage	On the day that you became eligible for Medicaid or premium assistance
All other qualifying events	Up to 30 days from the date of the event	As of the date of the event

Due to IRS regulations, elected coverage cannot begin until you have submitted your elections in the enrollment tool via the ***HR Service Portal*** or by calling the Benefits Service Center. Coverage is generally retroactive to the event date, as long as your elections are properly submitted within the designated election period.

Life Insurance

As a newly hired employee, your effective date for coverage is as stated in the **Eligibility for Employees** section. If you are absent from work on the effective date of coverage due to illness or injury, coverage will not begin until the first day you return to active work.

Coverage for new dependents begins the first day legally acquired, if properly enrolled. Coverage for adopted children begins either on the date of placement in your home or the adoption date. For Dependent Life Insurance, you must be actively at work on the day coverage is scheduled to begin. Coverage will not begin until the first day that you return to work. Additionally, if one of your dependents is hospitalized, confined to home under a doctor's care, disabled or applying for disability coverage on the day his or her coverage is scheduled to begin, that dependent's coverage will begin when he or she recovers and resumes normal activities.

You have 60 days to add a new child to the family using the ***HR Service Portal*** and linking him/her to the coverage. Special rules apply for Dependent Life. If you become eligible for Dependent Life (Life Insurance and Accidental Death & Dismemberment) at the time of your first eligible child's live birth, that newborn child will be covered, without enrollment, during the first 30 days of life. For coverage to continue after that timeframe, you must enroll the child for such insurance during the ***Plan's*** specified periods.

Note: If you have more than one child, and have not enrolled in Dependent Life, any subsequent newborn or newly acquired child will not have the coverage without enrollment in Dependent Life. Coverage is available from that date forward for new dependents.

If you marry or acquire a domestic partner (***ABR Partner***) while you are insured, your new spouse or partner will be covered for Dependent Life Insurance without enrollment, for the first 30-day period of eligibility; you must enroll your spouse or partner before the end of that period to maintain coverage.

Long Term Disability

For purposes of the Long-Term Disability Plan, a pre-existing condition limitation provision may apply. Please review the **Long Term Disability** chapter for more information.

Flexible Spending Accounts (FSAs)

Elected contributions to the health care and dependent care FSAs will begin with the first payroll after you submit your elections. You may claim expenses that occur only during your dates of participation. You need to re-enroll in the FSAs each ***Open Enrollment*** period if you want to participate. These benefits do not roll over automatically each year. However, up to $550 of unused Health Care FSA funds remaining at the end of the year will rollover to the next ***plan year***. An eligible rollover amount of less than $10.00 will be forfeited with no enrollment in the following plan year.

If you become eligible to elect an FSA, you may only open and contribute to an FSA if you submit your elections prior to November 1, as end-of-year processing precludes your enrollment during the last two months of the year.

When Does Coverage End?

For You

Your coverage ends the last day of the month in which the earliest of the following events occur, unless noted otherwise:

- Your employment with Providence Health & Services ends
- You are no longer eligible to participate in this ***Plan*** (for example, because of a reduction in your scheduled work hours)
- You move to a non-covered position
- You have been on an approved, continuous family or medical leave of absence for six months (regardless of pay status)
- You have been on an approved personal, educational or military leave of absence for two months (regardless of pay status)
- You are laid off
- You die (coverage ends on date of death)
- For Long-Term Disability, coverage ends on date employment terminates
- For the Dependent Care FSA, contributions are suspended while on a leave of absence.

If You Retire

Your active coverage ends on the last day of the month in which you retire. If you are enrolled in a Health Care FSA, you may only submit claims for services that were **incurred on or before** the day you retire. You will have the option to continue coverage through COBRA for the remainder of the ***plan year*** in which you retire which provides you with opportunities to submit claims for services during the COBRA period.

For Your Dependents

Coverage for your dependents ends on the same date your coverage ends; the last day of the month in which a dependent no longer meets the definition of "dependent," or the last day of the month in which your contributions for dependent coverage cease, whichever occurs first.

If you die, coverage for your dependents will end on the last day of the month of your death.

If you and your spouse are divorced, coverage for your spouse will end on the last day of the month in which the date of the final divorce decree occurs. If your relationship with your ***ABR*** ends, coverage for your ABR (and unmarried children of your ABR) will end on the last day of the month in which the domestic partnership is dissolved or you no longer meet plan criteria. For legal separation or annulment, coverage ends on the last day of the month in which the court grants the legal separation or annulment.

You must make your changes in the enrollment tool on the ***HR Service Portal*** within 30 days of the relationship ending. The enrollment tool will not allow late events to be entered; however, it is important that only eligible dependents are covered under the ***Plan***. If you are beyond 30 days from one of these events, please contact the Benefits Service Center at 888-615-6481 to report the event.

If your dependent child reaches age 26, coverage ends on the last day of the month. If an enrolled dependent child is ***physically or mentally disabled*** on the date coverage would otherwise end due to his or her reaching age 26, the child's coverage may be extended for as long as:

- The qualifying disability status continues
- The child continues to qualify for coverage in all aspects other than age
- You continue to be covered under the ***Plan***
- You continue to pay the required premium, as applicable

The ***Plan*** will require that you obtain a physician's statement certifying the physical or mental disability and/or your tax returns for your child's tax dependent status in order to cover your dependent child past the age of 26.

For information about continuing coverage, please review the **Optional Continuation of Coverage (COBRA)** chapter

Coverage During a Leave of Absence

Benefits coverage may continue during certain approved leaves of absence. Your benefits continue for up to six months if you are on an approved medical or FMLA leave, or up to two months if on an approved educational, military or personal leave. Providence will provide information on whether you qualify for benefits continuation at the time of your approved leave of absence. In no event will benefits continue beyond a six month period while you are on an approved unpaid medical leave.

Upon your return from leave, your benefits coverage may continue, or you may be required to reenroll for benefits, including life insurance coverage depending on whether your benefits had ended more than 30 days before you return to work in a benefits-eligible status. If you are on an unpaid leave of absence and you elected the Health Care FSA and/or HSA, payroll contributions not collected while on unpaid leave

will be collected from your paycheck when you return to work. You will receive an email notification advising you of the reenrollment requirement, if applicable. If you do not return from leave, your coverage ends for you and your dependents on the last day of the month in which your employment terminates.

Continuation of Benefits When Active Coverage Ends

Once your coverage ends, the following information describes resources and information, including next steps and your rights and responsibilities.

Medical, Dental, Vision, Health Care Flexible Spending Account and Caregiver Assistance Program

Your medical, dental, vision, Health Care FSA and Caregiver Assistance Program (CAP) benefits are subject to the federal program known as COBRA. Continuation of these benefits is outlined in detail in the **Optional Continuation of Coverage (COBRA)** chapter. You are not required to elect COBRA.

If you do not elect COBRA, your medical, dental, vision, Health Care FSA and CAP benefits end on the last day of the month of your change to unpaid status or termination. Health Care FSA claims must have been incurred prior to this date to seek reimbursement, unless you elect COBRA.

Health Savings Account

Your ***Health Savings Account*** remains available, even after your payroll contributions end and an individual account will be created for your continued use at Health Equity. Contact Health Equity at 877.372.6667 for additional information.

Dependent Care Flexible Spending Account

Your Dependent Care ***Flexible Spending Account*** is a benefit you elect to enable you and your spouse, if applicable, to work, attend school or look for work. If you are not at work due to a leave of absence, or you have left your position at Providence, you are no longer eligible to claim your Dependent Care expenses. While claims can be submitted through March 31 of the following year, service dates must occur while you were actively working. Contact Health Equity for additional information at 877-372-6667.

Life Insurance

You and your covered dependents can apply for conversion and/or portability coverage. Information regarding your conversion and portability options will be mailed to you. You must initiate conversion and pay your first premium within 60 days from the date coverage ended.

Accidental Death and Dismemberment Insurance

You and your covered dependents can apply for portability coverage. Information regarding your portability options will be mailed to you by the insurance carrier as a courtesy. You must apply and pay your first premium within 60 days from the date of your portability offer.

Long Term Disability Insurance

You may apply for conversion coverage unless you are disabled at the time your active coverage ends. To ensure you will not be subject to evidence of insurability, you must apply and pay your first premium

within 60 days from the date your active coverage ends. Information regarding conversion options will be mailed to you by the insurance carrier as a courtesy.

Still have questions?

Contact the Benefit Service Center at 888-615-6481 if you have any questions.

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials.

Adult Benefits Recipient (ABR), ABR Partner
See **Eligibility for Dependents**

Claims Administrator
A third party administrator or insurer designated by the plan administrator or its delegate to review and process claims for benefits under the Plan.

Dual coverage
If you and your spouse or ABR Partner or a parent and an adult child are both employed by Providence and eligible for benefits, it is considered dual (duplicate) coverage, and therefore not permitted under the plan (medical, dental, vision) for both individuals to cover each other.

Flexible Spending Accounts (FSAs)
The FSAs are designed to save taxes. You elect to fund the account at the beginning of the ***Plan Year*** through payroll deductions and then are reimbursed from your account for eligible expenses you incur during the Plan Year.

Health Savings Account (HSA)
A Health Savings Account (HSA) is a tax-advantaged savings account for employees enrolled in the HSA Medical Plan that allows you to use the funds in your HSA to pay for eligible medical, dental and vision out-of-pocket expenses for you, your spouse and your qualified tax dependents. You can contribute pre-tax dollars from your paycheck to your HSA. Your HSA is portable – the account is owned and managed by you and is always yours to keep.

Health Reimbursement Account (HRA)
If you enroll in the HRA Medical Plan and earn a health incentive, the health incentive will be deposited into a tax-free Health Reimbursement Account (HRA) in your name. You can use your HRA to pay for out-of-pocket health care medical expenses, such as the deductible, copays and coinsurance amounts for you and any dependents covered on the HRA Medical Plan. You can also use HRA funds for dental and vision expenses under the Providence dental and vision plans for you and your dependents enrolled in the HRA Medical Plan.

HR Service Portal
Electronic resource for benefits information available at **hrforcaregivers.org**. Health and Welfare benefit elections can be entered by selecting the *Benefits – enroll, review or update (BenefitConnect)* link on the homepage under **External Links**. Access to the Benefits Service Center for questions is also available by navigating to the **Request HR Help > Benefits > Benefits Questions**. Other HR tools and resource materials are available on the portal.

Medicare
A federal health insurance program for the elderly and disabled, consisting of hospital insurance (Part A), supplemental medical insurance (Part B), private health plan options (Plan C), and prescription drug benefits (Part D).

Open Enrollment
A defined time period when you and all other eligible employees are allowed to enroll yourself and/or your dependents for benefit coverage and make desired changes.

Physically or mentally disabled
The inability of a person to be self-sufficient as the result a physical or mental handicap, including but not limited to cerebral palsy, epilepsy, or another neurological disorder that is diagnosed by a physician as a permanent and continuing condition.

Plan
The Providence Health & Services Health and Welfare Plan, and inclusive of the individual benefits, under ERISA.

Plan Administrator
The Plan Administrator is the sole fiduciary of the Plan and has all discretionary authority and control over the operation and administration of the Plan. The Plan Administrator has the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, and unless there was an abuse of discretion, such discretionary determinations regarding plan terms and eligibility shall be binding upon all participants and upon the employers.

The Plan Administrator may choose to hire a consultant and/or contract with an administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner.

Plan Year
The 12-month period beginning January 1 and ending December 31.

Medical

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this***.

Your Medical Plan Options

Medical coverage is one of your most important and valuable benefits. Providence offers the following Medical plan options:

- HRA Medical Plan
- HSA Medical Plan
- Oregon EPO Medical Plan (where offered)
- Kaiser of Washington HMO Medical Plan, (where offered)
- Blue Shield Access+ HMO Medical Plan (where offered)
- Providence OptionPLUS HMO (where offered)
- No coverage (Waive)

Information about the HRA Medical Plan, HSA Medical Plan and Oregon EPO Medical Plan are provided in this chapter. The HSA Medical Plan is the ACA plan offered to employees with a payroll status less than 0.50 FTE.

All medical plans described in this chapter help you stay well by providing 100 percent coverage for ***in-network*** preventive care and help you when you are not well by covering a portion of your costs. The cost of your coverage depends on who you elect to enroll in medical coverage under your plan. Your enrollment category choice for medical does not affect your choice for dental or vision.

No Dual Coverage

The Plan does not allow ***dual coverage.*** Please review the **No Dual Coverage** section in the **Eligibility and Enrollment** chapter for more information

Choosing Medical Coverage

You choose your medical plan option and family category when you initially enroll. Then during the annual benefits ***Open Enrollment*** in the fall, you can update your medical option and family category elections for the following calendar year. Please review the **Eligibility and Enrollment** chapter for more information.

How do you decide which medical option is best for you? Consider the following questions:

- Which members of your family need coverage?
- What do you expect your medical expenses will be for the coming year?
- What will the various medical options pay for your expected level of expense and what is the associated cost?
- How well could you withstand a high level of medical expenses if you had higher ***deductibles*** and differing ***coinsurance***?
- Are you comfortable with receiving all of your care from ***in-network*** providers?
- Do you have any other coverage?

Note: Please review the Coordination of Benefits section of the General Medical, Dental, and Vision Information chapter for information about how this Plan's coverage works with other medical, dental or vision coverage you may have.

Considering the "No coverage (Waive)" Option

If you have medical coverage elsewhere, you may wish to consider the "No coverage (Waive)" option. Under this option, you will have no medical coverage through the Providence medical plans. If you lose your other medical coverage, you may enroll in a Providence medical plan outside of ***Open Enrollment***. Please review the **Eligibility and Enrollment** chapter for additional information.

Medical Plan Assistance Program (MPAP)

The Medical Plan Assistance Program (MPAP) is designed to ensure all ***benefits-eligible*** (0.5 – 1.0 FTE) employees can afford medical insurance by providing free or reduced-cost coverage to employees and their eligible dependents. MPAP eligibility is determined based on the annual household income and family size relative to the federal poverty guidelines, modeled on the Affordable Care Act. Refer to the ***HR Service Portal*** for the current federal poverty guidelines table to determine if you qualify for MPAP and additional eligibility criteria.

Benefits-eligible employees with household incomes up to 250% of the federal poverty guidelines who are enrolled in the HRA Medical Plan pay no contributions for the cost of coverage or a 50 percent discount on any available Providence medical plan. If enrolled in the HRA Medical Plan, eligible employees also receive an annual contribution to his or her HRA of $450*. (Note: The MPAP HRA contribution is reduced by 50% if assistance is approved to start July 1 or later.)

Benefits-eligible employees with household incomes up to 400% of the federal poverty guidelines receive a 50% discount on premiums on any available Providence medical plan.

Household income includes all taxable income from all sources of those living in the household, including you, such as:

- Wages, salaries, tips
- Unearned income, such as dividends, interest and pensions
- Alimony
- Unemployment compensation

*This amount is subject to change

The Medical Plan Assistance Program is a confidential program administered by Optum. In the search bar of the ***HR Service Portal***, type in **Medical Plan Assistance** for more information and a detailed chart of the current federal poverty guidelines. A link to the application is also available on the ***HR Service Portal***.

If you have any questions about this program or need help completing your application, call Optum. Translation services are available in Spanish and many other languages.

If approved, you will be notified via the email address you submitted on the MPAP application. The benefits administrator will be informed to adjust your payroll deductions accordingly. You may submit your MPAP program application at any time; however, if approved, the change in your paycheck deduction will apply going forward and won't be retroactive.

Generally, if your application is approved before the 18th of the month, the change will appear on your paycheck after the first of the next month. If your application is approved after the 18th of the month, the change will appear on the paycheck following the next month.

About Your Medical Benefits

Providence Health Plan (PHP) administers the ***self-funded*** plans for employees and dependents enrolled in the HRA Medical Plan, HSA Medical Plan and Oregon EPO Medical Plan.

These medical plans provide benefits only for ***covered services*** and supplies that are ***medically necessary*** for the treatment of a covered illness or ***injury***, and rendered by a ***physician***, practitioner, ***nurse***, ***hospital*** or specialized treatment facility as those terms are specifically defined in the **Glossary** for this chapter. The treatment must be generally accepted by medical professionals in the United States and may not be considered ***experimental*** or ***investigational***.

The plans pay benefits up to the ***allowable charge*** in the geographic area where ***services*** or supplies are provided. Any amounts that exceed these charges, such as expenses for ***out-of-network*** care, are not covered and are your responsibility.

No coverage is provided for treatment or services rendered outside the USA or its territories except for an urgent medical condition or a ***medical emergency***.

There are some differences that you should consider when selecting a medical plan:

- How much you pay for out-of-pocket for ***deductibles***, ***copayments*** and ***out-of-pocket maximums.***
- The HRA Medical Plan and Oregon EPO Medical Plan offers copayments not subject to the deductible for primary care visits, emergency room and ***generic drugs***.
- The companion savings account associated with the HSA Medical Plan - the Health Savings Account (HSA) – and how the Health Care Flexible Savings Account (FSA), if elected, interacts with the HSA.
- In-network providers may vary between plans. Refer to the **Using In-Network Providers if you are enrolled in the HRA Medical Plan, HSA Medical Plan and EPO Medical Plan Participants** for information on network differences.
- Your per-pay-period premium contribution.

How to Obtain Health Services Coverage

Who to Call		
Medical and retail pharmacy benefits	Providence Health Plan (PHP) Customer Service	800-878-4445 **https://healthplans.providence.org/members/member-groups/phs-caregivers**
• **Mail-order pharmacy**	Postal Prescription Services (PPS)	800-552-6694
• **Specialty prescription drug**	Credena Health	855-360-5476
Preauthorization Services requiring preauthorization are listed under **Prior Authorization/ Medical Review** and in the **Benefit Summary of Covered Medical Expenses** table. The list is subject to change. Contact PHP Customer Service for verification or questions.	Providence Health Plan (PHP) Customer Service	800-878-4445 **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101**

Your Medical ID card identifies you as a Plan ***participant*** and contains important information about your coverage and benefits. Please present your medical ID card each time you receive care.

If you lose your medical ID card, you may order a new one by contacting PHP Customer Service at 800-878-4445. Under no circumstances should you give your ID card to another person to use.

Using *In-Network* Providers if you are enrolled in the HRA Medical Plan or HSA Medical Plan

The HRA Medical Plan and the HSA Medical Plan allow you to choose any ***health care provider*** you wish, but in most cases, you will save money by using providers, facilities and services that are part of the ***in-network***/preferred provider networks. In addition, there are no claim forms to submit if you seek ***in-network*** care.

The plans pay a higher benefit if you use ***in-network providers*** and a lower benefit if you use providers, facilities or services that are not in the Plans' network, as shown in the **Benefit Summary of Covered Medical Expenses**. It is important that you or your covered dependents present your ID card when you obtain medical services, so that your provider knows what type of benefit plan you have.

Choosing a Provider for HRA Medical Plan and HSA Medical Plan Participants

The plans pay a different level of benefits depending on the type of ***provider*** you use:

Tier	Description	Level of Benefits	Contact Information
Tier I* Preferred Providers ***ACO network***	• All Providence and St. Joseph Health facilities, medical groups and clinics and select provider partners.	The highest level of coverage	Providence Health Plan 800-878-4445 To find a provider, visit **ProvidenceHealthPlan.com/findaprovider**
Tier II* In-Network Providers	• Includes providers and facilities that are not part of the ***ACO network*** but are contracted with PHP and Premera. • For Oregon-based caregivers: The PHP-contracted network. • Outside Oregon: Premera BlueCard PPO Network or the BlueCard Program through Premera.	A lower level of coverage than Tier I but a higher level of coverage than Tier III	Providence Health Plan 800-878-4445 To find a provider, visit **ProvidenceHealthPlan.com/findaprovider**
Tier III Out-of-Network Providers	• Facilities and providers that are generally not contracted with PHP, the Premera Blue Card PPO or the BlueCard Program through Premera. • Other facilities and providers designated as Tier III under the Plan.	The lowest level of coverage	Providence Health Plan 800-878-4445 To determine the network status of your provider, visit **ProvidenceHealthPlan.com/findaprovider** Tier III (out-of-network) providers do not appear in PHP's provider directory.

*Not all types of care facilities or providers may be represented ***in-network.***

In the event a highly-specialized service is only available at a limited number of facilities and not offered within the ***ACO network***, ***covered services*** by an ***in-network provider*** may be paid at the Tier II level, and not at the higher Tier I level. More information on coverage levels is provided in the **Your Cost Share Under the Plan** and **Benefit Summary of Covered Medical Expenses** sections.

Tier I

Services are covered at the highest level if you use a Tier I preferred provider. This network serves Providence employees with quality care and a greater level of care coordination designed to reduce gaps in care for better outcomes and a reduction in costs for you.

Tier II

In-network providers can also save you money because they have agreed to preferred rates for health care services. The qualifications of each physician, ***hospital*** and other provider have been reviewed with the intent of providing quality care at a discounted fee that is less than the general fee in the geographic area in which you receive services. They cannot bill you for the difference between their contracted network rate and their "retail," or non-contracted rate.

Tier III

Out-of-network benefits are payable for facilities and providers who are not contracted with PHP, Premera or other Blues network, or have been designated as Tier III providers by the Plan.

Providence Health Plan is the ***Claims Administrator*** and all questions on your medical plan coverage and claims should be directed to Providence Health Plan.

Out-of-network providers are providers who do not have a contract with PHP, Premera or other Blues network for discounted rates or other provisions. These providers are paid at the Tier III level, based upon Plan design. If you receive services from out-of-network providers, you will be subject to balance-billing between the out-of-network providers "retail" or non-contracted rate and the ***allowable charge,*** which will result in higher out-of-pocket expenses for you.

In some cases, a provider may have a contract with Premera, however, under the Providence Medical Plan, these providers are paid at the Tier III level, based upon Plan design. Due to the contracts with Premera, you can benefit from network discounts. You will generally not be responsible for balance-billing between the network discount rate and the "retail" or non-contracted rate for covered charges.

Note: If the contract between the *provider* and PHP or Premera ends at any time, there will no longer be a benefit from network discounts, and you will be responsible for balance-billing as described above.

It is your responsibility to contact PHP to determine the network status of your provider.

If You Are Out-of-Area or Live and Work Remote

You and your dependents can access health care from ***in-network providers*** through the BlueCard program:

- When you are away from home and out of your service area
- If you live and work outside the core Providence states (Alaska, California, Montana, New Mexico, Oregon, Texas, Washington)

As long as you use contracted providers, your benefits will be paid at the in-network rate, and you will receive the in-network discounted rates from the providers as well.

To access a national network provider, call Providence Health Plan Customer Service at 800-878-4445 and ask for the name of a national network provider or facility located where you need care.

You can also go online to the Providence Health Plan provider directory at **ProvidenceHealthPlan.com/findaprovider**, select "Browse by Provider Networks". You will be asked to choose plan type – select **Specific Employer Groups**. Under **Choose provider network,** select your PH&S plan**.** Then enter the location where you want to receive care and click the **Search** button. Follow prompts to select the type of care you need.

Present your medical ID card when you request care, and the provider will either bill Premera or the local ***Host Blue*** for you, or in some cases when you use an out-of-network provider, request payment directly and provide an itemized billing for your use in submitting a claim yourself.

Services Received Outside the United States

No coverage is provided for treatment or services rendered outside the United States or its territories except for an urgent medical condition or ***medical emergency***. If you are traveling outside of the United States and require treatment for an urgent medical condition or a medical emergency, payments you make for medical treatment may be reimbursed, provided the following guidelines are met:

- Participants must pay for medical services at the time of service
- Upon returning to the U.S., submit an itemized statement of charges that includes diagnosis and all charges paid; the exchange rate for foreign currency must also be noted on submitted forms
- Charges submitted must be for an accidental ***injury, emergency care*** or ***urgent care*** event.

For more information on how to submit a claim for reimbursement, please review the **General Medical, Dental and Vision** chapter for more information.

Network Providers

Please note, network providers, including Tier I providers, are subject to change at any time. Contact Providence Health Plan to confirm network status.

When you receive care from a PHP or ***Host Blue's*** network ***provider***, in most cases, there are no claim forms to submit because network providers will do that for you. In addition, your out-of-pocket costs may be less, as explained below. Under the ***BlueCard Program***, Providence Health Plan remains responsible for fulfilling their claims administration contractual obligations. However, the Host Blue is responsible for contracting with and handling all interactions with its network providers.

Whenever a claim is processed through the ***BlueCard Program***, the amount you pay for ***covered services*** is calculated based on the lower of:

- The provider's billed charges for your covered services, or
- The negotiated or discounted charge that the ***Host Blue*** makes available to Providence Health Plan.

Out-of-Network Providers

When ***covered services*** are provided by out-of-network (non-contracted) providers and facilities, the ***allowable charge*** will be determined by the network administrator and generally be based on their determination of allowable charge for out-of-network providers unless a different allowable charge is required by applicable state law. You are responsible for the difference between the amount that the out-of-network provider or facility bills and this Plan's payment for the covered services.

Choice of Primary Care Provider

The Plan considers physicians practicing in certain specialties (family practice, general practice, internal medicine, gynecology and pediatrics) as primary care physicians. You can visit any ***in-network provider*** in these specialties to receive the primary care physician benefit.

For information on how to select a primary care provider and for a list of network primary care providers, contact Providence Health Plan at 800-878-4445 or online at **providencehealthplan.com/findaprovider**. You do not need ***prior authorization*** from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Mental Health and Chemical Dependency Network

The network of mental health providers and chemical dependency providers is managed by Optum. To obtain ***prior authorization*** for mental health or chemical dependency services, call Providence Health Plan's authorizing agent, Optum at 800-711-4577. Providence Health Plan is the ***Claims Administrator*** and all questions on your medical plan coverage and claims should be directed to Providence Health Plan.

Using In-Network Providers if you are enrolled in the Oregon EPO Medical Plan

The Oregon EPO Medical Plan only provides benefits when you use ***in-network providers***, except in the case of ***emergency care***.

Choosing a Provider for Oregon EPO Medical Plan Participants

The plan provides coverage for care received ***in-network*** unless the procedure needed is not performed at a Providence facility or in the case of an emergency.

Tier	Description	Level of Benefits	Contact Information
In-network providers	• Providence Medical Group primary care physicians and specialists, and selected partners • Providence hospitals/facilities • Providence and Walgreens pharmacies Please note: In **Clark County**, only Providence Medical Group primary care physicians are in-network; *there are no in-network specialists or facilities in this area*.	The highest level of coverage *No benefits available from out of network providers, unless the procedure needed is not performed at a Providence facility or in the case of an emergency.*	Providence Health Plan 800-878-4445 To find a provider, visit **providencehealthplan.com/findaprovider**. *The list is subject to change at any time.*

Your Cost Share Under the Medical Plan and Medical Management

Annual Deductible

The annual ***deductible*** is the amount you (or your family) must pay each ***Plan Year*** before the Plan will pay for ***covered services***. Your deductible differs based on which providers you use, as shown in the table below. Regardless of where you receive services, your plan deductible will cross-accumulate. This means that charges incurred from out of network providers count toward their respective tier and the in-network deductible until the in-network deductible is met, and any additional charges incurred from out-of-network providers count toward your out-of-network deductible (until the out-of-network deductible is met).

For the **HRA Medical Plan and Oregon EPO Medical Plan**, as each individual pays for covered care, it counts toward his or her individual ***deductible*** as well as the family deductible. Once you satisfy the individual deductible, the Plan begins paying its share of the cost and you pay the rest. If the family meets their ***deductible***, the Plan begins paying its share of the costs for all covered family members. In this case, some individual family members may not have to meet the individual deductible if the family deductible is met first.

For the **HSA Medical Plan**, if employee-only coverage is elected, the Plan begins paying its share of the cost once the individual ***deductible*** is satisfied. If family coverage is elected, the deductible is not satisfied for any individual until the family deductible is met.

Annual Deductible (per calendar year)	HRA Medical Plan	HSA Medical Plan	EPO Medical Plan
In-network Employee only Family (2 or more participants)	$1,150 per person $2,300 per family	$1,500 for employee only coverage $3,000 for any level greater than employee only	$300 per person $900 per family
Out-of-network Employee only Family (2 or more participants)	$2,300 per person $4,600 per family	$3,000 for employee only coverage $6,000 for any level greater than employee only	**No out-of-network coverage**
Note: ***Eligible expenses*** cross-accumulate, which means expenses that count toward the in-network ***deductible*** will also apply toward the out-of-network ***deductible*** and vice versa.			

The following **do not** apply toward the annual ***deductible***:

- Charges for services and treatment that are not covered by the Plan
- Charges for services that are denied as not ***medically necessary*** or ***experimental***
- Charges from out-of-network providers over the allowable amount
- Charges that exceed any applicable benefit maximum (see **Benefit Maximums** below)
- ***Copayments*** or ***Coinsurance*** for services that do not apply to the deductible for the HRA and Oregon EPO medical plans
- Penalties incurred due to lack of ***prior authorization*** (assessed for Tier III claims)

Please refer to the **Benefit Summary of Covered Medical Expenses** section for benefits that are not subject to the ***deductible***.

Annual Out-of-Pocket Maximum

The annual ***out-of-pocket maximum*** is the most you will need to pay in a ***Plan Year*** for covered expenses. Your out-of-pocket maximum differs, based on which plan and providers you use, as shown in the table below. Regardless of where you receive services, your out-of-pocket maximum accumulators apply to the in-network and out-of-network provider tiers and cross-accumulate.

Annual Out-of-Pocket Maximum (per calendar year)	HRA Medical Plan	HSA Medical Plan	EPO Medical Plan
In-network			
Employee Only	$3,300 per person	$3,000 for employee only coverage	$2,500 per person
Family (2 or more participants)	$6,600 per family	$6,000 for any level greater than employee only	$7,500 per family Combined with pharmacy
Out-of-network			
Employee only	$6,600 per person	$6,000 for any level greater than employee only	**No out-of-network coverage**
Family (2 or more participants)	$13,200 per family	$12,000 for any level greater than employee only	
Note: ***Eligible expenses*** cross-accumulate, which means expenses that count toward the in-network ***out-of-pocket maximum*** will also apply toward the out-of-network out-of-pocket maximum and vice versa.			

For the **HRA Medical Plan and Oregon EPO Medical Plan,** each individual's payments for covered costs count toward an individual maximum as well as the family maximum. As soon as the individual meets his or her maximum, the Plan begins paying 100% of the covered costs for that individual; this includes any amounts paid toward the ***deductible***. If the family meets their ***out-of-pocket maximum***, the Plan begins paying 100% of the covered costs for all covered members of the family. In this case, some individuals may not have to meet the individual amount if the family amount is met first.

For the **HSA Medical Plan**, an employee who elects employee-only coverage will meet an individual out-of-pocket maximum, after which the plan will cover all eligible claims. If family coverage is elected, the family ***out-of-pocket maximum*** must be met before the plan begins covering all eligible claims. Individual out-of-pocket maximums do not apply to the HSA Medical Plan.

The following **do not** apply toward the annual ***out-of-pocket maximum***:

- Charges for services and treatment that are not covered by the Plan
- Charges for services that are denied as not ***medically necessary*** or ***experimental***
- Charges from out-of-network providers over the allowable amount
- Charges that exceed any applicable benefit maximum (see **Benefit Maximums** below)
- Charges for services paid by the Plan at 100%
- Penalties incurred due to lack of preauthorization

Benefit Maximums

Total plan payments for each covered person are limited to certain maximum benefits amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as a year or a lifetime.

Whenever the word “lifetime” appears in this Plan in reference to benefit maximums, it refers to the time you or your ***dependents*** are covered by any health plan provided by Providence.

For the HRA, HSA and Oregon EPO Medical Plans

Your medical plan will not pay more than the following for medical expenses incurred over you (or your dependents) lifetime:

Benefit	Maximum Benefit
Orthognathic Services, including TMJ	$3,000 per lifetime
Transplant Travel	One per lifetime; $250 per day, up to $5,000 lifetime benefit maximum for transportation, food and lodging
Bariatric Surgery and related travel	One per lifetime Travel - $250 per day, up to $5,000 lifetime benefit maximum for transportation, food and lodging
Diabetes prevention programs	Two program sessions per lifetime

Prior Authorization/Medical Review

Providence Health Plan (PHP) is contracted to help you and the Plan determine whether or not proposed services are appropriate. The program is not intended to diagnose or treat medical conditions, guarantee benefits or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness of ***hospital*** stays and proposed procedures. Nothing in this provision will increase benefits to cover a confinement or service that is not ***medically necessary*** or otherwise not covered. ***Prior authorization*** is NOT a guarantee of benefit payment.

Covered Services that Require Prior Authorization

Note: Not all services listed below are covered on all plans. Refer to the **Benefit Summary of Covered Medical Expenses** for ***covered services***.

As the patient, it is your responsibility to advise your physician/provider of the requirement for ***prior authorization*** if any of the services listed below are being recommended by your health care provider, and to ensure the prior authorization process under the Plan has been completed at least 48 hours before services are provided. Visit **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** for the most up to date information or contact PHP Customer Service at 800-878-4445 to verify if your service requires ***prior authorization***.

In the event of an emergency hospitalization, PHP needs to be notified within 48 hours or as soon as reasonably possible.

- All ***inpatient*** admissions (except emergency room care) including admission to a:
  - ***Hospital***
  - ***Skilled nursing facility***
  - Rehabilitation facility
  - ***Birthing Center***
- Select outpatient surgical procedures, including, but not limited to:

  - Miscellaneous cosmetic (if allowable)
  - Cervical, thoracic and lumbar spinal surgeries
  - All bariatric services
  - Uvulectomy, uvulopalatopharyngoplasty (UPPP), laser-assisted uvulopalatoplasty (LAUP)
  - Select hip, knee and shoulder procedures
  - Sleep studies and/or treatment of sleep disorders
  - TMJ services
  - All reconstructive surgery including, but not limited to, restoration of head/facial structures, breast reconstruction post-mastectomy, and as otherwise covered in this SPD
- All ***inpatient,*** residential, day, intensive outpatient, or partial hospitalization treatment for Mental Health and/or Chemical Dependency services
- Applied Behavioral Analysis (ABA)
- Organ/tissue and bone marrow transplants (including pre-transplant evaluations and HLA typing)
- High technology radiological/imaging services such as MRI, MRA, SPECT, CT, CTA, SE, TTE, TEE, nuclear cardiology and PET scans
- Genetic testing, including genetic testing for BRCA1 and BRCA2 mutation
- Neuropsychological testing
- Certain medical supplies, medical appliances, prosthetics and orthotics
- All treatment for medically-related dental services, except emergency room; including outpatient hospitalization and anesthesia for such dental services
- Services and procedures without specific CPT codes (unlisted services and procedures) will be reviewed at a claims level with chart notes
- Procedures, surgeries or treatment that may be considered ***experimental*** or ***investigational***
- Select ***durable medical equipment*** including, but not limited to, the following:
  - Power wheelchairs and supplies
  - Seat lift mechanisms
  - Select nerve stimulators
  - Skin substitutes
  - Oral appliances
  - Flexion/extension devices
  - Wound therapy pumps
  - Speech-generating devices
  - Rental of CPAP or purchase of CPAP post-trial rental period
- Nutritional services involving total parenteral nutrition (TPN) and medical foods
- Certain medications, including certain immunizations, received in your provider's office

Talk with your provider about getting ***prior authorization***. Often times a provider will obtain the prior authorization on your behalf. You can call Providence Health Plan Customer Service to verify if prior authorization has been obtained. If you do not obtain prior authorization for services received from an out-of-network provider, a financial penalty may apply.

NOTE: Prior authorization is not a treatment directive. The actual course of medical treatment that a participant chooses remains strictly a matter between the participant and their physician and is separate from the prior authorization requirements. Additional plan requirements may apply.

How to Obtain Prior Authorization

Providence Health Plan (PHP) will provide a prior authorization form upon verbal or written request. If you need information on how to obtain prior authorization, please call your Customer Service Team at the number listed on your Medical ID Card:800-878-4445.

Non-emergency ***inpatient***, residential and day treatment mental health and ***chemical dependency*** services and all outpatient chemical dependency services must have ***prior authorization*** by calling the number of your Medical ID Card for PBH (Optum): 800-878-4445.

If an emergency medical, mental health or chemical dependency condition prevents you from obtaining ***prior authorization***, you must call the PHP Customer Service within 48 hours following the onset of treatment or as soon as reasonably possible, to continue coverage of these services.

If You Do Not Obtain Prior Authorization

For all services subject to ***prior authorization***, if not obtained, and the service is deemed as not medically necessary, you could be responsible for the entire cost of the service received.

For the HRA and HSA medical plans, for ***out-of-network*** providers, you must contact PHP or ensure that your provider has obtained prior authorization, or you will have to pay 50% of the cost of the claim, up to $2,500. This penalty does not apply to the ***out-of-pocket maximum*** or to the ***deductible***.

Required Second Surgical Opinion

You must obtain a ***second surgical opinion*** when asked to do so by Providence Health Plan (PHP).

Second surgical opinions must be given by a physician who is certified by the American Board of Medical Specialties in a field related to the proposed surgery. The ***physician*** giving the opinion must also be independent of the physician who first advised surgery and is excluded from performing the surgery.

Second surgical opinions requested by PHP are paid at 100% with no ***deductible*** for the **HRA Medical Plan** and **EPO Medical Plan**. A second surgical opinion requested by PHP can be paid at 100% after the deductible has been met for the **HSA Medical Plan**. If surgery is not recommended in the second surgical opinion, you may still have the originally proposed surgery and receive regular plan benefits.

The intent of the second surgical opinion is primarily to ensure you have all the facts before having surgery.

If you have any questions about required or elective surgery, call PHP Customer Service.

Individual Care Management

Individual care management is available to help participants better manage their care in understanding a new diagnosis or assistance with navigating options for a diagnosis that has been affecting one's life for a long time. Personalized support is available for Case/Disease Management for certain health conditions such as Cancer, High Risk Maternity, Asthma/Chronic Obstructive Pulmonary Disease (COPD), and Heart Failure.

Interventions are personalized and may include, but are not limited to, assisting with navigating pre-service authorizations, health plan benefits information, personalized health education, community support resources and coordination of care.

For more information, contact PHP at 800-662-1121 (TTY: 711) or email **caremanagement@providence.org**

Pregnancy

In accordance with the **Newborns' and Mothers' Health Protection Act**, the medical plans do not restrict benefits for any ***hospital*** length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider or mother obtain authorization from PHP for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

Note: Newborn babies must be enrolled in the Plan within 60 days of birth by reporting the birth event via the ***HR Service Portal*** if you want to cover them under your plan. Once you have enrolled the newborn for coverage, you will also be asked to submit, or upload required dependent verification documentation within a specified timeframe after your new dependent is added to coverage.

Calling PHP does not enroll your baby in the benefit plan nor does adding them to the list of dependents in the benefits enrollment system on the ***HR Service Portal***.

HRA Medical Plan

You are responsible for covered expenses up to the annual ***deductible*** before the Plan begins paying, except for those services subject to a ***copayment***. If one person meets the individual deductible, the Plan begins paying for his or her ***eligible expenses***. Once the family deductible is met (if you have elected family coverage), additional members of your family do not have to satisfy an individual deductible that year before the Plan begins paying for their eligible medical expenses. (Note: if the in-network deductible has been met and you receive out-of-network care, you will pay for the eligible out-of-network charges until the out-of-network deductible is met.)

Visits to an in-network primary care or ***personal physician/provider*** are not subject to the ***deductible*** and you will pay only a ***copayment*** for non-preventive care. Generic formulary drugs also are not subject to the deductible, and you pay only a copayment per 30-day supply. Copayments do not apply to the deductible.

Once you have met your individual or family ***deductible***, the HRA Medical Plan pays its share of ***eligible expenses***, as indicated by the percentage in the **Benefit Summary of Covered Medical Expenses**. The Plan pays a higher percentage for inpatient or outpatient services provided by a facility that is part of the ACO Network (Tier I) or a Tier II facility. These charges count toward your ***out-of-pocket maximum***.

Once the ***out-of-pocket maximum*** has been met, the Plan begins paying ***eligible expenses*** at 100% for the remainder of the calendar year. If one person meets the individual out-of-pocket maximum, the Plan begins paying for his or her eligible expenses at 100%. Once the family out-of-pocket maximum is met (if you have elected family coverage), additional members of your family do not have to satisfy an individual out-of-pocket maximum that year before the Plan begins paying their eligible medical expenses at 100%.(Note: If the in-network out-of-pocket maximum is met and out-of-network care is received, you will have additional out-of-pocket costs until the (Tier III) out-of-network out-of-pocket maximum is met.)

Health Reimbursement Account (HRA)

Every employee covered under the HRA Medical Plan receives a related Health Reimbursement Account (HRA). While you are enrolled in the HRA Medical Plan, you can use this account to help pay for out-of-pocket medical expenses for you and your family members who are enrolled on the HRA Medical Plan and are ***eligible expenses*** under the HRA Medical plan. You can also use this account to help pay for out-of-pocket covered Providence dental or vision expenses.

If you complete the well-being activities each year, Providence will fund the account. The amount of annual funding will be based on the elected family coverage tier and completion of the required activities. Employees cannot contribute to their HRA. See **Health Incentive** for more information.

Note: If you are newly hired or benefits eligible on or after July 1 of the current year, you will receive 50% of the incentive for the current year and 100% of the incentive for the following year with no well-being activity completion required.

Using the Funds in Your HRA

After you enroll, you will receive a welcome kit from HealthEquity, the account administrator, and your HRA debit card with information on how to use your Visa card. Additional cards for covered family members can be requested from HealthEquity.

Your debit card can be used to pay for eligible out-of-pocket expenses for your medical, dental and vision plans. Present your Visa card at the pharmacy or write your card number on the return portion of the billing statement for physician, facility or dental bills.

If you use the HRA debit card, you may be required to provide substantiation, if requested by HealthEquity to ensure the services paid for with the card meet the IRS or plan requirements.

Expenses That Do Not Qualify

Expenses that do not qualify for reimbursement through the HRA include, but are not limited to:

- Services received prior to your effective date in the HRA Medical Plan
- Expenses for individuals and/or services not covered by the HRA Medical Plan
- Medical, dental and vision services and procedures (e.g., including but not limited to, cosmetic surgery, ***experimental/investigational*** services) not covered by the respective Providence plans.

Unused HRA Account Balances

Unused funds remaining in your HRA at the end of the year will roll over to the next year as long as you remain enrolled in the HRA Medical Plan. If you change medical plans, waive medical coverage or lose eligibility but remain employed by Providence, the unused funds remaining in your HRA are available for 365 days to submit covered expenses incurred while actively covered by the HRA Medical Plan. After this, any remaining funds will be forfeited. Under the Affordable Care Act, you have the right to opt out or waive your right to future reimbursements from your HRA as it impacts your ability to receive a tax credit in the Health Insurance Marketplace.

Funds in the HRA cannot be transferred to a Health Savings Account (HSA).

Pre-2016 Contributions with Five + Years of Service and Termination of Coverage

Refer to the **General Medical, Dental and Vision Information** chapter, **Health Reimbursement Account (HRA)** section for information regarding HRA funds if you were enrolled in the HRA Medical Plan prior to January 1, 2016 after five years or more of continuous employment (“Pre-2016 Funds”). The section includes information regarding the order of reimbursement for Pre-2016 Funds and other HRA funds, the claims filing period and Pre-2016 HRA funds at termination of employment. For questions, you may contact HealthEquity at 877-372-6667.

HSA Medical Plan

The HSA Medical Plan has an annual ***deductible*** and ***out-of-pocket maximums*** similar to the HRA Medical Plan except:

- Family coverage (any level greater than employee only) has no individual deductible; the full family deductible has to be met before the Plan begins paying benefits for anyone in the family.
- Family coverage (any level greater than employee only) has no individual out-of-pocket maximum; the full family out-of-pocket maximum has to be met before the Plan begins paying benefits at 100% for anyone in the family.
- There are no ***copayments*** under the HSA Medical Plan.

Health Savings Account (HSA)

If you enroll in the HSA Medical Plan, you may be eligible to open an individual Health Savings Account (HSA). You can use an HSA to pay for out-of-pocket medical, dental and vision expenses. It also has the following features:

- You have the opportunity to make contributions of your own money on tax-preferred basis if you are enrolled in the HSA Medical Plan **and** eligible for an HSA. See **HSA Eligibility** for details.
- Providence offers an HSA contribution to fund your account. The amount of funding is based on elected family coverage tier and completion of certain well-being activities.
- You can use the HSA to reimburse eligible out-of-pocket health expenses for you and your federal tax dependents, including medical, vision and dental expenses.
- Health Savings Account funds can grow over time with additional contributions and investment earnings – tax-free.
- Any unused funds are portable and not tied to employment with Providence – it's yours to save for future health care expenses, such as COBRA costs, long term care premiums or individual health benefit coverage, even into retirement, as allowed by the IRS

Please note: HSA contributions or earnings may be subject to state income taxes. If you live in a state that taxes the contributions or earnings, those state income taxes will apply. The Plan will comply with changes in state tax regulations.

HSA Eligibility

To open an HSA and to continue to make contributions once your account is open, you must:

- Be enrolled in a high-deductible health plan, like the HSA Medical Plan.
- Not be covered in any other non-high-deductible health plan, as defined by the IRS, including but not limited to:
  - Medicare
  - Medicaid
  - TRICARE (a military health system).
- Not be enrolled in a Health Reimbursement Account (HRA) that provides reimbursement for your coverage or a standard Health Care Flexible Spending Account (FSA).
- Not have received any Veteran's Administration health benefits in the past three months.
- Not be claimed as a dependent on another individual's tax return.

Note: If your spouse enrolls in their employer's FSA, you are eligible for benefits in that FSA, which makes you ineligible for an HSA even if you are not enrolled in your spouse's medical plan or your spouse is not enrolled In your medical plan.

During your enrollment process as a new hire, qualified status change and during ***open enrollment***, you will be asked HSA eligibility questions. If you are not eligible to open an HSA, you can still enroll in the HSA Medical Plan, but you will not be eligible to contribute to an HSA.

If you have coverage under another group health plan that is not a qualifying high-deductible health plan, you are not eligible to open or contribute to an existing Health Savings Account.

Upon receiving a welcome kit from HealthEquity after your enrollment in the HSA Medical Plan, please notify them if you are not eligible for a Health Savings Account. If you have been participating in a Health Savings Account and you gain coverage under another group health plan, you may no longer have contributions made to your account. If ineligible contributions have been made, you may notify HealthEquity to initiate removing the funds from your account. You will also need to submit this change as a qualifying event in the benefits enrollment system on the ***HR Service Portal*** to ensure no more contributions are made to your account.

Contributing to Your HSA

You can contribute money to your HSA through pre-tax payroll contributions to your HSA. You can elect payroll contributions in the benefits enrollment system when you enroll. Payroll contributions can be changed throughout the year.

Select the **Enroll, review or update benefits** button from the ***HR Service Portal*** home page and navigate to HSA Caregiver Contributions. Your new election must be submitted at least 10 days before the pay date you want the change to take effect.

The IRS set the 2021 maximum contribution limit of $3,600 for individual coverage and $7,200 if you cover dependents. If you're 55 or older, you can add $1,000 to this annual maximum. The HSA contribution maximum is subject to change annually.

The maximum you can elect to contribute from your paycheck takes into account the potential health incentive amounts that could be earned. If you did not earn the health incentive and would like to contribute up to your IRS maximum, please contact HealthEquity to make a contribution via check or directly from your personal bank account.

Note: If you are newly hired or benefits eligible on or after July 1 of the current year, you will receive 50% of the incentive for the current year and 100% of the incentive for the following year with no well-being activity completion needed. Employees who submit elections after December 1 will not receive health incentive contributions for that year.

Using the Funds in Your HSA

You will receive a welcome kit with a debit Visa card that can be used to pay for ***eligible expenses***. Present your Visa card at the provider's office, pharmacy or write your card number on the return portion of the billing statement for physician, facility, dental or vision bills. Additional cards for covered family members can be requested from HealthEquity.

Additional information on the Health Savings Account, including examples of what expenses can be reimbursed from your HSA, is available in **IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans.** Funds in the HSA cannot be transferred to the HRA.

Oregon EPO Medical Plan

You are responsible for covered expenses up to the annual ***deductible*** before the Plan begins paying, except for those services subject to a ***copayment***. If one person meets the individual deductible, the Plan begins paying for his or her ***eligible expenses***. Once the family deductible is met (if you have elected family coverage), additional members of your family do not have to satisfy an individual deductible that year before the Plan begins paying for their eligible medical expenses.

Visits to an in-network primary care or ***personal physician/provider*** are not subject to the ***deductible*** and you will pay only a ***copayment*** for non-preventive care. Generic formulary drugs also are not subject to the deductible and you pay only a copayment per 30-day supply at an in-network pharmacy. ***Copayments*** do not apply to the deductible.

Once you have met your individual or family ***deductible***, the Oregon EPO Medical Plan pays its share of ***eligible expenses***, as indicated by the percentage in the **Benefits Summary of Covered Medical Expenses.**

Once the ***out-of-pocket maximum*** has been met, the Plan begins paying ***eligible expenses*** at 100% for the remainder of the calendar year. If one person meets the individual out-of-pocket maximum, the Plan begins paying for his or her eligible expenses at 100%. Once the family out-of-pocket maximum is met (if you have elected family coverage), additional members of your family do not have to satisfy an individual out-of-pocket maximum that year before the Plan begins paying their eligible medical expenses at 100%.

The Oregon EPO Medical Plan pays a share of eligible expenses, as indicated by the percentage in the **Benefits Summary of Covered Medical Expenses.** These charges count toward your out-of-pocket maximum.

Health Incentive

The health incentive program is an annual program that offers well-being activities to you and in return, Providence provides you with the opportunity to earn health incentive funds.

You must meet the activity requirements for each new ***plan year*** to earn the health incentive. If you choose to earn the health incentive, you are required to complete the well-being activities. Information on how to earn your health incentive will be announced in a timely manner.

The health incentive you can earn depends on the medical plan you enroll in in the current plan year:

- If enrolled in the HRA or HSA medical plan, your health incentive will be deposited into your HRA account or HSA account, as applicable, typically no later than the end of January. You must be eligible for the HSA account to receive the health incentive funds (refer to the **HSA Eligibility** section above.)
- If enrolled in the EPO medical plan or an HMO, you will receive a premium credit for participation in the well-being activities.

Note: If you enroll in medical coverage on or after July 1 of the current *plan year* (or became eligible for benefits on or after July 1), if eligible for the HSA or HRA, your health incentive is prorated and reduced by 50% for the current year. You will automatically receive the full health incentive next year.

If you are unable to participate in one of the activities to earn the health incentive and are interested in learning whether you qualify for an accommodation, please contact Virgin Pulse at 888-671-9395 as soon as possible, and prior to the program deadline.

Important notes regarding the health incentive

- For employees who update their HSA eligibility answers in the ***HR Service Portal*** from HSA-ineligible to HSA account- eligible, updates made between July 1 - December 1 will receive 50% of the eligible incentive. Any changes to HSA-eligibility answers made on or after December 2 will not receive health incentive funding for the current plan year.
- Employees who submit an enrollment election in the HSA Medical Plan after December 1 will not receive HSA health incentive funding for the current plan year.
- Terminated employees on COBRA are not eligible to receive HSA health incentive funding.
- ACA (including per diem/non-benefits-eligible) employees are not eligible to receive HSA or HRA health incentive funding.
- Health incentive deposits received in error must be returned to the Plan.

Benefit Summary of Covered Medical Expenses – HRA and HSA Medical Plan

All services are subject to the **Medical and Pharmacy Benefits Exclusions** in addition to any service-type exclusions listed in the Benefit Summary.

The following table describes the HRA and HSA medical plan benefits. For each benefit, the Plans pay a percentage of the covered amount depending on where you seek care.

Refer to **Choosing a Provider for HRA Medical Plan** and **HSA Medical Plan Participants** for the definition of Tier I, Tier II and Tier III providers.

Benefit	HRA Medical Plan	HSA Medical Plan
Certain expenses do not apply to the ***out-of-pocket maximum***, including but not limited to: services not covered by the Plan (even if recommended by a physician), services in excess of a maximum benefit limit, fees in excess of ***allowable charges*** and penalties paid for not obtaining required ***prior authorization***.		
Acupuncture		
May include ***medically necessary*** adjunctive therapy when provided with ***acupuncture*** course of treatment for neuromusculoskeletal disorders, nausea or pain. For services provided by a licensed acupuncturist.	**Subject to the *deductible*.** **Office visits:** • Plan pays 80% of the covered amount, you pay remainder of the billed amount. Up to a maximum of 12 visits for acupuncture and spinal manipulations combined allowable in a ***Plan Year***. Limit does not apply to charges for office visits, lab or X-ray services. Amounts that apply to the ***deductible*** also apply to the benefit limit.	
Allergy Services		
Allergy shots, allergy serum, injectable medications and total parenteral nutrition (TPN)	**Subject to the *deductible*.** **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.	
Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorder		
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 in the diagnosis of autism spectrum disorder. Benefits include coverage for any other non-excluded mental health or medical services identified in the individualized treatment plan.	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 75% of the covered amount; you pay remainder of the billed amount. ***Prior authorization*** **is required.**	

Benefit	HRA Medical Plan	HSA Medical Plan
ABA (continued) An approved ABA treatment plan is subject to review and may be modified or discontinued if review shows that you or your covered dependent who is receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. Services may be provided in the member's home or a licensed health care facility. There are no frequency limitations.		
Exclusions: Services provided by a family or household member; services that are custodial in nature, or that constitute marital, family, educational or training services; respite care, creative arts therapy, social counseling, music therapy, chelation or hyperbaric chambers; services provided through community or social programs or an individual education plan in accordance with the Individuals with Disabilities Education Act; services provided by the Department of Human Services or other applicable state agency, other than employee benefit plans offered by the department and the authority.		
Cancer Screening and Non-Surgical Treatment		
Routine cancer screening • Covered as Preventive Services in accordance with the Adult Preventive Care schedule under the Plan and the Patient Protection and Affordable Care Act of 2010. • Mammogram: at any age • Prostate cancer screen: for one prostate specific antigen (PSA) or DRE per calendar year – beginning at age 40. • Colorectal cancer screening exam or tests for fecal blood test, flexible sigmoidoscopy, colonoscopy, barium enema – beginning at age 50 (under age 50, covered under Outpatient Surgery benefit).	**See below for the *deductible.*** **In-network: Not subject to the *deductible.*** Plan pays 100% of the covered amount, you pay 0%. **Out-of-network: Subject to the *deductible.*** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.	
Colonoscopy scheduled for other than screening exam, based on ***medical necessity***.	**Subject to the *deductible.*** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount; you pay remainder of the billed amount. **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount; you pay remainder of the billed amount.	

Outpatient chemotherapy or radiation therapy	**Subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount; you pay remainder of the billed amount. **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount; you pay remainder of the billed amount.
Clinical trials relating to cancer	**Subject to the *deductible*** and ***coinsurance*.** **In-network:** Coverage is available under standard plan provisions for care provided by the health care practitioners associated with the clinical trial that would otherwise be covered (preventive services, diagnosis, treatment, palliative care). ***Prior authorization*** **may be required. Contact PHP to verify.** **Out of network:** Not covered.
Chemical Dependency	**See Mental Health and Chemical Dependency**
Chiropractic Services	
• Office visits for diagnosis, evaluation and treatment planning for musculoskeletal conditions • Related diagnostic x-rays and laboratory services for the diagnosis and evaluations of musculoskeletal conditions • 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 that are ***medically necessary*** for the treatment of neuromusculoskeletal disorders, including one unit of massage therapy per visit when billed with manipulation	**Subject to the *deductible*.** **Any licensed chiropractor:** Plan pays 80% of the covered amount for spinal manipulations, you pay the remainder of the billed amount. Up to a maximum of 12 visits for acupuncture and spinal manipulations combined allowable in a ***Plan Year***. Limit does not apply to charges for office visits, lab or X-ray services.
Exclusions: Services of a chiropractor which are not within the scope of practice, as defined by state law; charges for care not provided in an office setting; maintenance or preventive treatment consisting of routine long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.	

Dental Services and Dental Anesthesia	
Dental services received after an accidental ***injury*** to natural teeth, which occurred while covered under the Plan. Conditions for receiving this benefit • For emergent treatment of dental trauma: When problem is diagnosed, and treatment plan delineated within 72 hours of trauma; and • For other corrective dental treatment following dental trauma: Need for corrective treatment must be identified and the treatment initiated within 12 months of dental trauma. **Outpatient facility** charges and related anesthesia charges for dental services for children under age 7, developmentally disabled children or developmentally disabled adults (these services are not otherwise provided under the Medical Plan)	**Subject to the *deductible*.** **Professional Services:** • **In-network**: Plan pays 80% of the covered amount, you pay 20%. • **Out-of-network:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount; you pay remainder of the billed amount. **Anesthesia:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount; you pay remainder of the billed amount. ***Prior authorization*** **is required for all treatment, except emergency services.**
Exclusions: Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth and/or gums, wisdom teeth, areas surrounding the teeth and dental implants), except as approved by Providence Health Plan.	
Diabetic Care	
Annual preventive exams • Dilated retinal exams by a qualified participating eye care specialist • Glycosylated hemoglobin (HbA1c) test • Urine test to test kidney function • Blood test for lipid levels as appropriate • Visual exam of mouth and teeth by a personal physician/provider or other provider (dental visits are not covered) • Foot inspection without shoes or socks NOTE: With the exception of the dilated retinal exam, all of the above may be performed in your provider's office at the time of your annual exam. The eye exam may be done by an eye care specialist. Exams may be performed more often than once a year if your provider decides they are ***medically necessary***. Additional exams and tests are subject to the ***deductible*** and ***coinsurance***.	**Annual preventive exams:** **See below for the *deductible*.** • **In-network**: **Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. • **Out-of-network: Subject to the *deductible***. Plan pays 50% of the covered amount, you pay the remainder of the billed amount. **Additional exams billed with a medical diagnosis:** **Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.

Diabetes supplies (covered under **Preventive Care** services) • Glucose control solution • Glucose monitoring supplies • Insulin pump supplies (including vials of pump-compatible insulin for Type 1 diabetes) • Lancets and lancet devices • Needles • Syringes • Test strips Note: Insulin pumps (which include OmniPod Insulin Management Systems) and blood glucose meters, readers and transmitters for continuous blood glucose monitors are covered under your ***durable medical equipment*** benefit.	**See below for the *deductible*.** • **In-network: Not subject to the *deductible***. Plan pays 100% of the covered amount, you pay 0%. • **Out-of-network: Subject to the *deductible***. Plan pays 50% of the covered amount, you pay the remainder of the billed amount.
Diabetes self-management education program Initial self-management education program. Your provider can recommend a specialist or facility that provides these services. You must be enrolled on the date services are received through the program for benefits to be paid.	**See below for the *deductible*.** • **In-network: Not subject to the *deductible***. Plan pays 100% of the covered amount, you pay 0%. • **Out-of-network: Subject to the *deductible*.** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.
Diagnostic X-ray and Laboratory Outpatient	
Diagnostic charges **for X-ray and laboratory services** • Allergy testing • Pre-admission testing (PAT) • Ultrasound Includes contrast materials (dyes) that may be required for a diagnostic procedure.	**Subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. ***Prior authorization*** **is required for high-technology radiological/imaging services such as MRI, MRA, SPECT CT, CTA and PET scans.**
Dialysis Outpatient	
Renal Dialysis	**Subject to the *deductible*.** **Facility:** • **Tier I**: Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. **Physician/Provider:** • **Tier I**: Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount.

<table>
<tr><th colspan="3">Emergency and Urgent Care Services</th></tr>
<tr><td>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.

If you are admitted to a non-participating hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.</td><td colspan="2">Subject to the deductible.

• Tier I: Plan pays 90% of the covered amount, you pay 10%.
• Tier II: Plan pays 80% of the covered amount, you pay 20%.
• Tier III: Plan pays 50% of the covered amount, you pay remainder of the billed amount.</td></tr>
<tr><td>Emergency Care (Hospital)
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:
• Acute abdominal pain
• Bleeding that does not stop
• Heart attack
• Loss of consciousness
• Medically necessary detoxification
• Poisoning
• Serious burn
• Severe chest pain
• Stroke
• 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.</td><td>Not subject to the deductible.

Facility:

• You pay $250 copayment per visit, the Plan pays the remainder

Copayment is waived if patient directly admitted from emergency room.

Physician/Provider:
• In-network: Plan pays 100% of the covered amount.</td><td>Subject to the in-network deductible.

Facility:

• Plan pays 80% of the covered amount, you pay 20%.

Physician/Provider:
• In-network: Plan pays 80% of the covered amount, you pay 20%.</td></tr>
<tr><td colspan="3">An “Emergency Medical Condition” is a medical condition that manifests itself by 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 place the health of a person (or a fetus in the case of a pregnant woman) in serious jeopardy.

“Emergency Services” are those health care items and services furnished in an emergency department. Services include all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

Plan benefits cover Emergency Services in the emergency room of any hospital. Emergency department 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.</td></tr>
</table>

Emergency Care **(Hospital) (continued)** When you are admitted to an out-of-network ***hospital*** from the emergency room or an ***urgent care*** facility, your ***inpatient*** services are covered under your ***in-network*** benefit until your condition becomes stable. Once your condition is stabilized, PHP 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 PHP has 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. You are responsible for the difference between the amount that the out-of-network provider or facility bills and this Plan's payment for the ***covered services***.

Equipment and Supplies	
Durable medical equipment Including expenses related to necessary setup, repairs, and maintenance. A statement is required from the prescribing physician describing how long the equipment is expected to be necessary and whether the equipment is ***medically necessary***. This statement will determine whether the equipment will be covered and if covered whether rented or purchased. If approved for rental, the Plan will pay the equipment rental cost up to the purchase price of such equipment. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition, because of normal wear and tear, or because purchase of new equipment is less expensive than repair of existing equipment.	**Subject to the *deductible*.** **In-network:** Plan pays 80% of the covered amount, you pay 20%*. **Out-of-network:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. ***Prior authorization required*, including but not limited to:** • Diabetic glucose/insulin pumps/OmniPods/continuous blood glucose monitors • Select nerve stimulators • Flexion/extension devices • Oral appliances • Power wheelchairs and supplies • Rental of CPAP • Purchase of CPAP post-trial rental period (new ***prior authorization*** required prior to CPAP purchase) • Seat lift mechanisms • Skin substitutes • Speech generating devices • Wound therapy pumps *Diabetes supplies covered at 100%; not subject to the ***deductible***
Exclusions: Includes but is not limited to: **Bed-related items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses. **Bath-related items**: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats and spas. **Chairs, lifts and standing devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer) and auto-tilt chairs. **Fixtures to real property:** ceiling lifts and wheelchair ramps. **Car/van modifications. Air-quality items:** room humidifiers, vaporizers, air purifiers and electrostatic **machines. Blood/injection-related items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors. **Other equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.	
Hearing aids **$1,500 benefit for hearing aids for both ears combined, every 36 months (rolling)** [see **Preventive Care** for Hearing Exam benefit]	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.
Exclusions: Hearing aid batteries	

Other equipment and supplies • Medical devices that are surgically implanted into the body to replace or aid function: artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition or if replacement is less expensive than repair of existing prosthesis • Original fitting, adjustment, and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired (Replacement of such devices will be covered only if the replacement is necessary due to a change in the physical condition of the covered person or because of normal wear and tear.) • Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment • Orthopedic or corrective shoes and other supportive appliances for the feet when prescribed by a covered ***health care provider*** • Orthotics • Blood and/or plasma, and the equipment for its administration, including autologous blood transfer	**Subject to the *deductible*.** • **In-network**: Plan pays 80% of the covered amount, you pay 20%. • **Out-of-network:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. **Limits:** • Orthotics benefit limited to $500 in covered expenses every calendar year. • Jobst stocking limited to two pair per calendar year • Wigs (cancer and alopecia diagnosis only) $150 per calendar year limit; the in-network ***deductible*** applies to the $150 limit.
Exclusions: Includes but is not limited to: prefabricated foot orthoses, cranial banding, cranial orthoses. Other similar devised are excluded except when used postoperatively for synostotic plagiocephaly; orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; orthoses primarily used for cosmetic rather than functional reasons; and orthoses primarily for improved athletic performance or sports participation.	
Family Planning	
Contraceptive services Includes over-the-counter contraceptives, spermicides or barrier devices.	Not covered by **PH&S**. Please contact Providence Health Plan directly for information on obtaining coverage for these items**.**
Female sterilization	Not covered by **PH&S**. Please contact Providence Health Plan directly for information on obtaining coverage for these items**.**
Male sterilization	Not covered.
Termination of pregnancy	Not covered.

Genetic Testing	
BRCA1 and BRCA2 mutation Testing must be specifically ordered by the treating physician. Genetic testing for BRCA1 and BRCA2 mutation, specifically included as a benefit, will be limited to once per lifetime. Coverage of this testing shall not be construed in any manner to be authorization for coverage of either prophylactic mastectomy or oophorectomy.	**Not subject to the *deductible*.** **In-network:** Plan pays 100% of the covered amount, you pay 0%. **Subject to the *deductible*.** **Out-of-network**: Plan pays 50% of the covered amount, you pay remainder of the billed amount. ***Prior authorization* is required.**
Other genetic screening and counseling 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 and therapeutic in nature.	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. ***Prior authorization* is required for genetic testing.**
Exclusions: Genetic testing which does not provide a definitive diagnosis or risk classification OR which does not guide treatment decisions or clinical management, will be excluded and not covered.	
Home Health Care	
Up to 130 home health care visits per calendar year Each visit by a person providing services under a home health care plan or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care service is considered one home health care visit.	**Subject to the *deductible*.** • **In-network:** Plan pays 80% of the covered amount, you pay 20%. • **Out-of-network**: Plan pays 50% of the covered amount, you pay remainder of the billed amount.
All ***covered services*** for home health care must be skilled services and do not include coverage for ***custodial care***. 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. Rehabilitation services provided under an authorized home health care plan will be covered as home health care services. Exclusions: charges for mileage or travel time to and from your home; wage or shift differentials for home health providers; charges for supervision of home health providers; or 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.	

Hospice Care	
Hospice care is a coordinated program of home care and ***inpatient*** care for a terminally ill patient, combined with support for the patient's family. The program provides for special needs arising from physical, psychological, spiritual, and economic stresses people experience during the final stages of a terminal illness.	**Subject to the *deductible*.** • **In-network:** Plan pays 100% of the covered amount, you pay 0%. • **Out-of-network**: Plan pays 100% of the covered amount, you pay 0% plus any amounts that exceed the covered amount. ***Prior authorization*** **is required.**

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.
2. The ***covered services*** provided are reasonable and necessary for the condition and symptoms being treated.

Hospice Care covered services and supplies include:

- Charges made by a ***hospice facility***, ***hospital***, or ***skilled nursing facility***, which are for:
  - Room and board and other services and supplies furnished to a person while a full-time ***inpatient*** for pain control and other acute and chronic symptom management.
  - Services and supplies furnished to a person while not confined as a full-time inpatient.
- Charges made by a hospice care agency for:
  - Nursing care provided by an RN or LPN, these consist of caring for the person
  - Medical social services under the direction of a physician, including: assessment of the person's social, emotional and medical needs and the home and family situation; identification of the community resources which are available to the person; and assisting the person to obtain those resources needed to meet the person's assessed needs
  - Psychological and dietary counseling
  - Consultation or case management services by a physician
  - Physical and occupational therapy
  - Home health aide services, these consist of caring for the person
  - Medical supplies
- Drugs and medicines prescribed by a physician
- Charges made by the providers below, but only if the provider is not an employee of a hospice care agency and such agency retains responsibility for the care of the person:
  - A physician for consultant or case management services
  - A physical or occupational therapist
- A ***home health care agency*** for:
  - Physical and occupational therapy
  - Home health aide services, these consist of caring for the person
  - Medical supplies
  - Drugs and medicines prescribed by a physician
  - Psychological and dietary counseling

Exclusions: Any charge for daily room and board in a private room over the facility's semiprivate room rate; bereavement counseling; funeral arrangements; pastoral counseling; financial or legal counseling (including estate planning and the drafting of a will); homemaker or caretaker services (these are services not solely related to care of the person including: sitter or companion services for either the person who is ill or other members of the family, transportation, housecleaning, and maintenance of the house); respite care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Palliative Care Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information and choice.	Covered as any other benefit, by the medical service rendered.
Hospital and Specialized Facilities	
Hospital* – *inpatient* acute care, Inpatient rehabilitation** • Room and board, not to exceed the semi-private room charge. If a private room is the only accommodation available, the Plan will cover an amount equal to the hospital's average semi-private room rate. • ***Intensive care unit (ICU) and coronary care unit • Miscellaneous hospital services and supplies required for treatment during a hospital confinement	**Subject to the *deductible*.** **Inpatient, Acute Care Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. ***Prior authorization* is required for all inpatient admissions.** For emergency admissions, Providence Health Plan must be notified within 48 hours or as soon as reasonably possible.
Skilled Nursing Facility No limit.	**Subject to the *deductible*.** • **In-network:** Plan pays 80% of the covered amount, you pay 20%. • **Out-of-network:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. ***Prior authorization* is required for all *skilled nursing facility/inpatient*** admissions**.** For emergency admissions, Providence Health Plan must be notified within 48 hours or as soon as reasonably possible.
Hospital – Outpatient Includes ***ambulatory surgical facility***, and ***birthing center***. Some outpatient procedures require ***prior authorization*.** Contact PHP to verify if required.	**Subject to the *deductible*.** **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II**: Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount **Outpatient Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. No coverage available if ambulatory surgical facility is not contracted with Providence Health Plan, Premera and other networks under the BlueCard program.

Infertility	
Infertility Testing and Counseling Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when performed for the sole purpose of diagnosing. Diagnostic services include hysterosalpingogram, laparoscopy and pelvic ultrasound.	**Subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 80% of the covered amount, you pay 20%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. The maximum ***allowable charge*** for screening for infertility testing/counseling is $500 per calendar year. The ***deductible*** applies to the $500 limit.
Exclusions: Treatment of infertility (including surgical); infertility related drugs or injectables; reversal of reproductive sterilization; artificial insemination including cost of acquiring semen; in vitro and in vivo fertilization or services supporting in vitro fertilization; services for non-member surrogate mother; all services associated with surrogate parenting; fees for surrogate parent; services, supplies, drugs, and procedures for reproductive disorders, defects, and/or inadequacies, whether or not the consequence of Illness, disease, or ***injury***; disorders, defects, and/or inadequacies shall include, but not be limited to: impotency, frigidity, infertility, sterility, and reversal of surgical sterilization.	
Infusion Therapy	
A type of care involving non-self-administered intravenous drugs ***Prior authorization*** may be required. Contact PHP to verify.	**Subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount.

<table>
<tr><th colspan="3">Maternity and Pregnancy</th></tr>
<tr><td>Prenatal as preventive care, including obstetrical specialist for high-risk pregnancy.

For amniocentesis and ultrasound services, see Diagnostic x-ray and laboratory benefit.</td><td colspan="2">See below for deductible.

• In-network: Not subject to the deductible. Plan pays 100% of the covered amount, you pay 0%.
• Out-of-network: Subject to the deductible. Plan pays 50% of the covered amount, you pay remainder of the billed amount.</td></tr>
<tr><td>Delivery and postnatal care, including obstetrical specialist for high-risk pregnancy.</td><td>See below for the deductible.

Physician/Provider:

• In-network: Not subject to the deductible. Plan pays 100% of the covered amount, you pay 0%.
• Out-of-network: Subject to the deductible. Plan pays 50% of the covered amount, you pay remainder of the billed amount.
For delivery facility, see Hospital and Specialized Facilities benefit.</td><td>Subject to the deductible.

Physician/Provider:

• Tier I: Plan pays 90% of the covered amount, you pay 10%.
• Tier II: Plan pays 80% of the covered amount, you pay 20%.
• Tier III: Plan pays 50% of the covered amount, you pay remainder of the billed amount.
For delivery facility, see Hospital and Specialized Facilities benefit.</td></tr>
<tr><td>Breastfeeding counseling and support

Covered under the terms of the Plan and the Patient Protection and Affordable Care Act of 2010.

Includes breast pump rental or purchase.</td><td colspan="2">Not subject to the deductible.

Lactation Counseling

• In-network: Plan pays 100% of the covered amount, you pay 0%.
• Out-of-network: Plan pays 100% of the covered amount, you pay the balance of any uncovered charges.

Equipment/Supplies

• In-network: Plan pays 100% of the covered amount for purchase of breast pump equipment and supplies at in-network providers, including retail outlets (e.g., Target).
• Out-of-network: Plan pays 100% of the covered amount, you pay remainder of the billed amount.

Plan pays 100% of heavy duty hospital grade electric pump for the duration of breastfeeding.</td></tr>
<tr><td colspan="3">Exclusions: Maternity expenses of non-member surrogate, services by a midwife unless licensed or certified nurse midwife or a nurse practitioner midwife, home and water births.</td></tr>
</table>

<table>
<tr><th colspan="3">Mental Health and Chemical Dependency</th></tr>
<tr><td>Inpatient services

Inpatient, residential, and day treatment or partial hospitalization for the treatment of mental or chemical dependency disorders, including detoxification must be obtained at an approved treatment facility.

Non-emergency inpatient, residential and day treatment mental health and/or chemical dependency services are covered benefits only when prior authorized by Optum at 800-711-4577 under standards generally applied by Optum. Optum is available as a resource for outpatient services and will work with your qualified practitioner to coordinate your care.

If you have concerns about the confidentiality of mental health or substance abuse treatment in an in-network facility, treatment elsewhere may be covered at the in-network rate, with prior authorization by Optum.</td><td colspan="2">Subject to the deductible.

Inpatient Facility:
• Tier I: Plan pays 90% of the covered amount, you pay 10%.
• Tier II: Plan pays 75% of the covered amount, you pay 25%.
• Tier III: Plan pays 50% of the covered amount, you pay remainder of the billed amount.

Day Treatment Facility:
• Tier I: Plan pays 90% of the covered amount, you pay 10%.
• Tier II: Plan pays 80% of the covered amount, you pay 20%.
• Tier III: Plan pays 50% of the covered amount, you pay remainder of the billed amount.

Residential Services:
• Tier I: Plan pays 90% of the covered amount, you pay 10%.
• Tier II: Plan pays 75% of the covered amount, you pay 25%.
• Tier III: Plan pays 50% of the covered amount, you pay remainder of the billed amount.

Prior authorization is required.</td></tr>
<tr><td rowspan="2">Outpatient Services

Outpatient diagnostic evaluation and mental health treatment, including individual and group therapy.

Outpatient diagnosis and treatment for chemical dependency. Treatment includes individual and group therapy.

Optum, at 800-711-4577, is available as a resource for outpatient services and will work with your qualified practitioner to coordinate your care.</td><td>See below for deductible.

In-network: Not subject to the deductible. Plan pays 100% of the covered amount, you pay $0. Not subject to the deductible.

Out-of-network: Subject to the deductible. Plan pays 50% of the covered amount, you pay the remainder of the billed amount.</td><td>Subject to the deductible.
• Tier I: Plan pays 100% of the covered amount, you pay 0%.
• Tier II: Plan pays 100% of the covered amount, you pay 0%.
• Tier III: Plan pays 50% of the covered amount, you pay remainder of the billed amount.</td></tr>
<tr><td colspan="2">Certain services may require prior authorization. Call PHP to verify if required.</td></tr>
<tr><td colspan="3">Exclusions: Conditions other than mental or chemical dependency disorders specified in the current edition of the Diagnostic and Statistical Manual of Disorders (DSM); services provided under a court order or as a condition of parole or probation; personal growth services, such as assertiveness or consciousness raising; treatments which do not meet the national standards for mental health or chemical dependency practice; counseling related to career treatments involving the use of methadone if such treatment is not part of a medically supervised treatment program that has been prior authorized by Optum; non-emergency inpatient, residential and day treatment, and all chemical dependency treatments if not prior authorized by Optum.</td></tr>
</table>

Naturopathic Care	
Examination, clinical laboratory, diagnostic x-ray, office visit consultation, and/or adjunct therapy delivered by a naturopathic physician within a course of treatment that includes natural treatment methods, modalities, nutritional advice, recommendation of homeopathic protocols	**Subject to the *deductible*.** **Licensed naturopathic physician.** Plan pays 80% of the covered amount, you pay the remainder of the billed amount. See preventive care for these services when performed by a naturopathic provider.
Exclusions: Any services not within the scope of license to practice for a naturopathic physician, as defined by your state law. See **Medical and Pharmacy Benefits Exclusions** for additional services not covered by the plan for any practitioner.	

Newborn Care Inpatient		
Newborn services are covered separately from services for the delivering mother. Subject to the newborn being enrolled in medical coverage. Newborn nursery care is a facility service covered under your ***hospital*** services benefit. All other services provided to a newborn, including physician/provider services, are covered under the applicable benefit level.	**Not subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount.	**Subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount.
Reminder: Coverage of newborns is not automatic. If you want to enroll the newborn, you must complete enrollment within 60 days of the date of birth (or date of placement for adoption), including required documentation. Contacting Providence Health Plan does not add the child to coverage.		

Nutrition	
Preventive nutritional counseling Nutritional counseling sessions in a calendar year for any diagnosis. No limit.	**See below for the *deductible*.** • **In-network: Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. • **Out-of-network**: **Subject to the *deductible*.** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.
Nutritional services Medical foods are covered for supplemental 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. Medical foods are defined as foods that are formulated to be consumed or administered internally under strict medical supervision for the treatment of inborn errors of metabolism.	**Subject to the *deductible*.** • **In-network**: Plan pays 80% of the covered amount, you pay 25%. • **Out-of-network**: Plan pays 50% of the covered amount, you pay the remainder of the billed amount. Approval of these services will be based on criteria established by Providence Health Plan and in accordance with regulatory requirements. ***Prior authorization*** **is required.**
Exclusions: Medical foods do not include total parenteral nutrition (TPN); this is covered under allergy shots, serums and injectable medications.	

Physician/Health Care Provider		
Primary care provider office visit for non-preventive services Can be a physician/provider specializing in family practice, internal medicine, general practice, obstetrics/gynecology, or pediatrics. You can use a Providence retail clinic, e-visits or phone visits.	**See below for the *deductible*.** • **In-network: Not subject to the *deductible*.** You pay $20 ***copayment*** per visit; the Plan pays 100% of the remainder of the covered amount. • **Out-of-network: Subject to the *deductible*.** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 90% of the covered amount; you pay 10%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.
Express Care Virtual visit With Express Care Virtual, you can receive virtual consultation from a licensed Providence primary care physician or nurse practitioner for common health conditions such as cough, cold, flu, headaches, eye infections or sinus infections using a computer, smart phone or tablet.	**Not subject to the *deductible*.** Plan pays 100%, you pay 0%.	**Subject to the *deductible*.** Plan pays 100%, you pay 0%. Deductible waived in 2021 under temporary federal guidelines.
Non-primary care provider/Specialist visit No referral required.	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.	
Inpatient hospital visit	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.	
Other office procedures, other professional services (radiology, pathology)	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.	
Prescription Drugs		
Prescription drugs	Please review the **Prescription Drugs** section for more information. Eligible prescription drug charges apply to the shared ***deductible*** and ***out-of-pocket maximum***.	

Preventive Care	
Well-child care Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. Includes covered preventive care, including routine immunizations/shots for children under the provisions of the Patient Protection and Affordable Care Act. For more information: https://www.healthcare.gov/what-are-my-preventive-care-benefits/children Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status.	**See below for the *deductible*.** **In-network: When billed as preventive care, not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. To receive in-network benefit, services must be provided by a primary care provider. Note: You may have out-of-pocket costs due to the ***deductible*** and/or ***copayment*** or ***coinsurance*** for the office visit if the preventive service is not the primary purpose of the visit or if your doctor bills you for the preventive services separately from the office visit. **Out-of-network: Subject to the *deductible*.** Plan pays 50% of the covered amount, you pay the remainder of the billed amount
Adult preventive care Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. Recommended guidelines for periodic exams: • Age 20 – 29: one exam every five years • Age 30 – 49: one exam every two years • Age 50 and older: one exam every year • Ancillary services, such as immunizations, are covered at the specified benefit levels when billed separately by the provider. Includes the covered preventive care services under the provisions of the Patient Protection and Affordable Care Act. For more information: https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults	**See below for the *deductible*.** **In-network: When billed as preventive care not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. To receive in-network benefit, services must be provided by a primary care provider. You may have out-of-pocket costs due to the ***deductible*** and/or ***copayment*** or ***coinsurance*** for the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit. May be performed by naturopath. **Out-of-network: Subject to the *deductible*.** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.

Well-woman visit/women's preventive care Gynecological exams and Pap tests, (mammograms, see Cancer screening), and women's health preventive care and screenings supported by the Health Resources and Services Administration. Includes the covered preventive care services, including routine immunizations/shots, under the provisions of the Patient Protection and Affordable Care Act. For more information: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/women**	**See below for the *deductible*.** **In-network: When billed as preventive care, not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. To receive in-network benefit, services must be provided by a primary care provider. You may have out-of-pocket costs due to the ***deductible*** and/or ***copayment*** or ***coinsurance*** for the office visit if the preventive service is not the primary purpose of the visit or if your doctor bills you for the preventive services separately from the office visit. May be performed by naturopath. **Out-of-network: Subject to the *deductible*.** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.

Laboratory services for preventive care
 	
Including, but not limited to, Pap smear, CBC, urinalysis, chemical profile, and glucose.
 	
For more information:
 	
https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults
	See below for the *deductible*.
	
	In-network:
	
	• **If billed with preventive diagnosis, not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%.
	• **If billed with diagnosis other than preventive, subject to the *deductible* and the follow apply:**
	  • **Tier I:** Plan pays 90% of the covered amount and you pay 10%.
	  • **Tier II:** Plan pays 80% of the covered amount and you pay 20%.
	
	Out-of-network: Subject to the *deductible*. Plan pays 50% of the covered amount, you pay the remainder of the billed amount.

Hearing Exam $250 maximum covered expenses per calendar year.	**See below for the *deductible*.** **In-network: Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. **Out-of-network: Subject to the *deductible*.** Plan pays 50% of the covered amount, you pay the remainder of the billed amount.

Rehabilitative and Habilitative Services – Outpatient	
Short-term outpatient rehabilitative and habilitative services are covered up to 75 visits* per calendar year, all therapies combined (physical therapy, speech therapy, occupational therapy and neurodevelopmental therapy). Therapy is provided by physicians and/or licensed or registered therapists to restore or improve function lost due to illness or ***injury***. Benefits are limited to ***covered services*** that can be expected to result in the significant improvement of the condition. The treatment must be part of a written treatment plan prescribed by a qualified provider. This benefit includes treatment for Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder not otherwise specified. ***The 75-visit calendar-year limit does not apply to treatment of mental health conditions.**	**Subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay remainder of the billed amount. ***Prior authorization*** **is required for neuropsychological testing.**
Exclusions: Exercise programs; Rolfing, polarity therapy, and similar therapies; and growth and cognitive therapies, including sensory integration and treatment of developmental delay except for diagnosed neurodevelopmental conditions.	
Sleep Disorders	
Treatment of sleep disorders and/or sleep studies Home sleep studies are also covered.	**Subject to the *deductible*.** **Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 50% of the covered amount, you pay 50% • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20% • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. ***Prior authorization*** **is required.**
Exclusions: Services not having prior authorization by the Claims Administrator.	

Surgery and Anesthesia	
Surgeon's expenses for the performance of a surgical procedure, and the services of an assistant surgeon not to exceed 20% of the ***allowable charge*** of the primary surgeon or in accordance with PPO contract limits. Anesthesia, when administered by a licensed anesthesiologist or certified registered nurse anesthetist (C.R.N.A.) in connection with a surgical procedure.	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. ***Prior authorization*** **is required for select surgical procedures. Contact PHP to verify if required.**
Breast reconstruction A covered person will be covered for all stages of one breast reconstruction/reduction on the non-diseased breast to make it equivalent in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed following a mastectomy. A prosthesis may be covered after a mastectomy if recommended by the treating physician following the mastectomy.	**Subject to the *deductible*.** (See the Hospital and Specialized Facilities benefit for facility coverage.) • **Tier I:** Plan pays 90% of the covered amount, you pay 10% • **Tier II:** Plan pays 80% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. ***Prior authorization*** **is required.**
Coverage for breast reconstruction and related services will be subject to all applicable ***deductible***, ***copayments*** and ***coinsurance*** amounts that are consistent with those that apply to other benefits under the Plan. The Plan will at all times comply with the terms of the **Women's Health and Cancer Rights Act of 1998** and will not deny a patient eligibility to enroll or to renew coverage, under the terms of the Plan, solely to avoid the requirements of this section. Additionally, the Plan will not penalize the patient or physician, or induce him or her to provide care to a participant in a manner inconsistent with this provision. Any Plan exclusions or limitations that exclude the benefit described above are hereby omitted to the extent that they specifically prohibit the above coverage.	
Reconstructive surgery **Correction of a congenital defect or congenital anomaly** To restore the anatomy and/or functions of the body which are lost or impaired due to an illness or ***injury***. Head/facial structures: restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including malocclusion of the jaw, when services are ***medically necessary*** for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing.	**Subject to the *deductible*.** (See the **Hospital and Specialized Facilities** benefit for facility coverage.) • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 25%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. ***Prior authorization*** **is required for select surgical procedures. Contact PHP to verify if required.**
Exclusions: Cosmetic surgery (primarily to preserve or improve appearance); dental services including, but not limited to, orthodontia, tooth decay, impacted teeth; orthognathic surgery to shorten or lengthen jaw unless related to injury or neoplastic/degenerative disease.	

Temporomandibular Joint (TMJ) and Orthognathic Services	
A diagnostic examination including a history, physical examination and range of motion measurements, as necessary; diagnostic X-rays; physical therapy of necessary frequency and duration; therapeutic injections; surgery; therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite Coverage of the appliance/splint is under the provisions of this section. The benefit for the appliance splint therapy will include an allowance for diagnostic services, office visits and adjustments. Surgical services. Orthognathic services, including surgical treatment of TMJ, only when there is significant evidence of pathology as a result of illness or ***injury***. Illness refers to a neoplastic process, degenerative disease or infection.	**Subject to the *deductible*.** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. The benefit is limited to $3,000 per lifetime. ***Prior authorization*** **is required for select surgical procedures. Contact PHP to verify if required.**
Exclusions: Dental or orthodontia services	
Tobacco Cessation	
Covered under the terms of the Plan and the Patient Protection and Affordable Care Act of 2010. Coverage is provided for participation in a PHP-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. Also includes participation in the Alere Quit for Life® Program.	**See below for the *deductible*.** **In-network: Not subject to the *deductible*.** Plan pays 100% of the covered amount; you pay 0%. **Out-of-network:** Not covered.
Transplants, Human Organ/Tissue	
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 participant) • From and replaced in the same person's body (a self-donor who is a participant) 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.	**Subject to the *deductible*.** **Inpatient Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** ** (see below) **Surgeon/Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II**: Plan pays 80% of the covered amount, you pay 20%. • **Tier III: ****** (see below) ***Prior authorization*** **is required.**

Transplant, Human Organ/Tissues, continued To qualify for coverage, all transplant-related services, procedures, treatment protocols, and facilities must have ***prior authorization*** by Providence Health Plan to be ***medically necessary*** and medically appropriate according to national standards of care, including initial consultation, evaluation, transplant facilities, donor evaluation, donor services, HLA typing, pre-transplant care, self-donation services, transplant services, and follow-up treatment.

NOTE: ***Prior authorization*** is not a treatment directive. The actual course of treatment that a participant chooses remains strictly a matter between the participant and their physician and is separate from the prior authorization requirements.

**Services provided at a facility that is not in Providence Health Plan credentialed Centers of Excellence or Providence St. Joseph Health affiliate transplant programs may be covered with Providence Health Plan prior authorization at Tier III level (subject to deductible 50% of the covered amount, you pay the remainder of the billed amount).

Covered Services:
Once ***prior authorization*** is received, ***covered services*** for transplants are limited to services that:

- Are provided at a facility that is in Providence Health Plan-credentialed Centers of Excellence or Providence St. Joseph Health affiliate transplant program (payable as Tier I and Tier II facilities)
- Involve one or more of the following organs or tissues:
  - Allogeneic hematopoietic stem cell/bone marrow/cord blood
  - Autologous hematopoietic stem cell/bone marrow
  - Heart
  - Kidney
  - Liver
  - Lung
  - Pancreas
  - Small bowel
- 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 and high-dosage chemotherapy for stem cell/bone marrow/cord blood transplants.

Travel expenses	
Travel expenses require ***prior authorization*** and are available for either the recipient and one companion, or recipient and the donor for ***medically necessary*** services related to an approved transplant. Travel benefits are paid if the recipient is required to travel 100 miles each way or more from his or her home address for the medically necessary services related to an approved transplant, or if the facility requires the patient to remain within a certain distance of the facility during the transplant process.	**Subject to the *deductible*.** **Travel benefit (when facility is being paid at Tier I or Tier II level):** $250 per diem food and lodging; mileage reimbursement at federal IRS rates with minimum travel distance between home and provider of 100 miles each way. $5,000 lifetime maximum for travel expenses; food and lodging per diem applies to the $5,000 lifetime maximum for travel expenses. ***Prior authorization*** **is required.**

Exclusions: Charges for alcohol, tobacco, laundry, telecommunications, and transportation that exceed coach-class rates.

Services for transplant donors Covered when both of the following apply: • The transplant recipient is a member of the Plan and is eligible for transplant benefits • The donor is not eligible for coverage of donation services under any other health benefit plan or government funding Covered services for donors include: • Initial evaluation of the donor and related program administration costs • Preserving the organ or tissue, transporting the organ or tissue to the transplant site • Acquisition charges for cadaver or live donor • Services required to remove the organ or tissue from the donor • 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	**Subject to the *deductible*.** **Inpatient Facility:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 75% of the covered amount, you pay 25%. • **Tier III:** Services provided at a facility that is not a Providence Health Plan credentialed Centers of Excellence or Providence Health & Services affiliate transplant programs may be covered with Providence Health Plan ***prior authorization*** at tier III level (subject to deductible 50% of the covered amount, you pay the remainder of the billed amount. **Physician/Provider:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20%. • **Tier III:** Plan pays 50% of the covered amount, you pay the remainder of the billed amount. ***Prior authorization*** **is required.**
Benefits for outpatient medications	Benefits for outpatient medications and antirejection (immunosuppressive) drugs are covered under the prescription drug benefits.
Exclusions: Any transplant procedure performed at a transplant facility that has not been approved by Providence Health Plan; any transplant that is ***experimental and investigational***, as determined by Providence Health Plan; services or supplies for any transplant that are not specified as ***covered services***, such as transplantation of animal organs or artificial organs; services related to organ/tissue donation by a member of the Plan 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.	
Transportation	
Ambulance Services for emergency medical transportation by state- certified ambulance and certified air ambulance transportation. Ambulance services are provided for transportation to the nearest facility capable of providing the necessary care or to a facility specified by Providence Health Plan.	**Subject to the *deductible*.** Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required for air ambulance services except in medical emergencies.**
Exclusions: Care cars, other medical transportation vehicles and other non-emergency medical transportation services; air ambulance transportation for non-emergency situations unless authorized by Providence Health Plan in advance.	

Travel Vaccinations and Related Medications	
Covered vaccinations and related medications • Hepatitis A vaccine • Malarone • Bacillus Calmette-Guerin (BCG) vaccine • Rabies vaccine • Typhoid vaccine • Yellow fever vaccine • Diphtheria Toxoid vaccine • Cholera vaccine • Plague vaccine • Japanese encephalitis virus vaccine	**Not subject to the *deductible.*** **For immunizations:** • **In-network:** Plan covers services in full. • **Out-of-network:** Not covered. **For travel counseling billed with immunization:** • **In-network:** Plan covers one travel counseling visit in full. • **Out-of-network:** Not covered. **Travel immunizations do not require *prior authorization*.**
Weight Management	
Bariatric Surgery Coverage of open laparoscopic Roux-en-Y Gastric Bypass surgery. Sleeve Gastrectomy and Biliopancreatic Bypass with Duodenal Switch for obesity is provided along with other approved procedures in accordance with medical policy and criteria established and maintained by Providence Health Plan	**Subject to the *deductible*.** **Inpatient Facility:** • **Tier I *:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Not covered. • **Tier III:** Not covered. **Professional Fees:** • **Tier I:** Plan pays 90% of the covered amount, you pay 10%. • **Tier II:** Plan pays 80% of the covered amount, you pay 20% only when procedures are performed at designated facility. • **Tier III:** Not covered. *Must be performed at a Providence St. Joseph Health facility Benefits are limited to one bariatric procedure per lifetime. Must be ***medically necessary*** and performed at a designated facility. ***Prior authorization*** **is required.**
Bariatric Surgery - Travel expenses Travel expenses require preauthorization and are available for the surgical patient and one companion for ***medically necessary*** services related to an approved bariatric procedure. Travel benefits are paid if the recipient is required to travel 100 miles each way or more from his or her home address for the ***medically necessary services*** related to an approved bariatric procedure. Charges for alcohol, tobacco, laundry, telecommunications, and transportation that exceed coach-class rates are not covered.	**Subject to the *deductible*.** **Travel Benefit:** $250 per diem food and lodging; mileage reimbursement at federal IRS rates with minimum travel distance between home and provider of 100 miles each way. $5,000 lifetime maximum for travel expenses; food and lodging per diem applies to the $5,000 lifetime maximum for travel expenses. ***Prior authorization*** **is required.**
The surgery and related services, including complications, will be covered as any other medical condition and subject to applicable plan limits. Services to stabilize complications from previous bariatric surgery covered by the Plan will be subject to current plan provisions in place at the time of the complications.	

Bariatric Surgery Exclusions: Open vertical banded gastroplasty; laparoscopic vertical banded gastroplasty; open and laparoscopic adjustable gastric band; gastric balloon; intestinal bypass surgery other than listed above and any procedure(s) associated with it; supplemental fasting; other treatments for obesity.	
Diabetes Prevention Program (DPP)	
Programs target: • Weight management/reduction, • Nutrition/eating habits, and • Activity • Approved in-network PHP partner programs include: — Omada — PREVENT — HMR	**In-network: Not subject to the *deductible*.** • Preventive service covered at 100% for employees, spouses, Adult Benefits Recipients (ABR) or adult child over age 18, after eligibility is determined • Lifetime limit of two program sessions **Out-of-network:** Not covered.

Prescription Drug Benefits – HRA and HSA Medical Plans

Benefit	HRA Medical Plan	HSA Medical Plan
	Retail, preferred retail and mail-order pharmacies: Up to 90-day supply	
Annual Deductible and Out-of-Pocket Maximum		
See the **Benefit Summary of Covered Medical Expenses** for combined ***deductible*** and ***out-of-pocket maximums*** for medical care and prescriptions drugs.		
Providence St. Joseph Health Pharmacies, Walgreens Pharmacies and Participating Pharmacies*		
Formulary ACA and Enhanced preventive generic and *brand drugs*	**Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%	
Generic drugs	**Not subject to the *deductible*.** You pay $10 per 30-day supply, the Plan pays the remainder.	**Subject to the *deductible*.** Plan pays 90% of the covered amount, you pay 10% up to a maximum of $150** per 30-day supply.
Formulary *brand drugs*	**Subject to the *deductible*.** **PSJH/Walgreens Pharmacies:** Plan pays 80% of the covered amount, you pay 20% up to a maximum of $150** per 30-day supply. **All Other Participating Pharmacies:** Plan pays 70% of the covered amount, you pay 30% up to a maximum of $150** per 30-day supply.	
Non-formulary *brand drugs*, including preventive drugs	**Subject to the *deductible*.** **PSJH/Walgreens Pharmacies:** Plan pays 60% of the covered amount, you pay 40% up to a maximum of $150** per 30-day supply. **All Other Participating Pharmacies:** Plan pays 50% of the covered amount, you pay 50% up to a maximum of $150** per 30-day supply.	
Specialty drugs	**Subject to the *deductible*.** Plan pays 80% of the covered amount, you pay 20% up to a maximum of $150** per 30-day supply. Limited to a 30-day supply per fill. Medications must be purchased from Credena Health or a PSJH pharmacy.	
Mail order (where available) for 90-day supply from designated mail-order pharmacy	**Subject to the *deductible* as noted above.** Not all prescriptions are eligible for mail-order pharmacy. Your share of the cost is three times that of a 30-day supply as shown above, including three times the amount of the maximum for ***brand drugs***. See below "**Ordering prescriptions by mail**" for preventive prescription drugs requirement.	
Non-Participating Pharmacy		
Not covered.		

* Not all areas will have a PSJH/Walgreens pharmacy available.
** The $150 maximum per 30-day supply will apply once the deductible has been met.

Contact Providence Health Plan for more information regarding specialty medications, including which pharmacies must be used for coverage.

For the current formulary list, visit the Providence Health Plan website at **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** which also notes those medications considered preventive under the IRS definition.

ACA and Enhanced Preventive Drugs

Affordable Care Act (ACA) preventive drugs are generic or brand medications included on the Plan formulary, and required to be covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.

A medication is considered preventive under the IRS definition when it is generally prescribed to prevent certain risks, complications or recurrence of a disease or condition

The Internal Revenue Code regulations governing HSA-qualified plans provide for a “safe harbor” for qualifying preventive medications, allowing these safe harbor medications to be exempt from the ***deductible***. The preventive formulary does not include any drug or medication used to treat an existing illness, ***injury*** or condition.

The preventive drugs covered by the plans administered by PHP are subject to formulary and tier status, as well as pharmacy management programs such as ***prior authorization***, step therapy and/or quantity limits. Refer to “**Ordering prescriptions by mail**” for additional information.

For the current formulary list, visit the Providence Health Plan website at https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101 or call PHP Customer Service at 1-800-878-4445.

Providence Health & Services sponsors your group health plan and has certified that it qualifies for a temporary enforcement safe harbor with respect to the Federal requirement to cover contraceptive services without cost sharing. Please contact Providence Health Plan directly for information on obtaining coverage for these items.

Specialty Drugs

Specialty drugs are prescriptions that are injectable, infused, oral or inhaled therapies that require specialized delivery, handling and administration, and are generally high cost.

These drugs must be purchased through Credena Health. ***Specialty drugs*** are indicated on the Providence Health Plan formulary list as “Specialty” in the status column. To view the formulary, visit **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** or contact the Customer Service Team at 800-878-4445.

Self-injectable drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration, and are on the Plan formulary. ***Prior authorization*** is generally required for the drug.

Using a Participating Pharmacy

Your prescription drug benefit requires that your prescriptions be filled at pharmacies that participate with Providence Health Plan. A list of the participating pharmacies is available on the website at **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101**. You also may contact PHP Customer Service if you need help locating a ***participating pharmacy*** near you or when you are away from your home.

Please present your identification card at the participating pharmacy. You may purchase up to a 90-day supply of each maintenance drug at one time using a preferred retail pharmacy or participating mail order pharmacy after an initial 30 day supply fill of the drug. See the **Prescription Drug** section for ***copayments/coinsurance***.

Normally, diabetes supplies and inhalation spacer device are obtained from a ***durable medical equipment*** (DME) supply house and the DME provisions apply. However, for your convenience, diabetes supplies and inhalation spacer devices may be obtained at your participating pharmacy.

Ordering Prescriptions by Mail

Participating mail-order pharmacy information is available on the Providence Health Plan website at **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** or call PHP Customer Service at 800-878-4445. Your physician or ***provider*** may call in the prescription or you can mail your prescription to a ***participating pharmacy***.

Not all prescription drugs are available by mail order. Providence Health Plan determines which drugs qualify for purchase by mail.

If your prescription is eligible, you may purchase up to a 90-day supply of each maintenance medication. See the **Prescription Drug** section for ***copayments/coinsurance*** information.

Enhanced preventive prescription drugs on the PHP formulary drug list that are covered at 100% must be obtained through PHP's designated mail order pharmacy. You may receive your first two refills at a network retail pharmacy; however, after those two fills, participants must use the designated mail order pharmacy to be covered by the medical plan.

If you have existing prescriptions at another pharmacy and would like to transfer them to the participating mail-order pharmacy, contact the mail order pharmacy directly. We recommend that you order refills approximately two weeks before you expect to run out of your current supply of medication. Payment is required before your order is processed. If there is an important change in the participating mail-order pharmacies, you will be notified at least 30 days in advance.

Use of Non-Participating Pharmacies

Urgent or emergency medical situations may necessitate the use of a non-participating pharmacy. If this occurs, you will need to pay full price for your prescription at the time of purchase. You may be reimbursed by the Plan upon submission of a Prescription Drug Reimbursement Request form, which can be obtained from the website at or by contacting PHP Customer Service and requesting one be sent to you. After you have completed and signed the form, submit it, along with your itemized pharmacy receipts, to the address listed on the form. Once received, your claim will be reviewed (submission of a claim does not guarantee payment). If your claim is approved, you will be reimbursed the cost of your prescription, subject to Plan benefits and limitations, less your applicable ***copayment***, or ***deductible*** and ***coinsurance***.

Quantities

- Prescription dispensing limits:
  - Opioids up to 7 days of initial dispensing
  - Topical, up to 60 grams
  - Liquids, up to eight ounces
  - Tablets or capsules, up to 100 dosage units
  - 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.
  - Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. ***Prior authorization*** is required for amounts exceeding any applicable medication dispensing limits.
- Drugs or hormones to stimulate growth are covered only if there is a laboratory-confirmed diagnosis of growth hormone deficiency. These drugs are covered only for children under age 18 and for adults only if there is documented pituitary destruction and the drug use meets the medical policy criteria.
- Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount and must meet PHP's medical necessity criteria and be purchased at a ***participating pharmacy***. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered.
- ***Specialty drugs*** are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). In rare circumstances, specialty medications may be filled for greater than a 30-day supply. In these cases, an additional specialty cost share may apply.

Approved Drugs – Limitations and Prior Authorization

All drugs must be FDA-approved, ***medically necessary*** and require, by law, a prescription to dispense. Not all FDA-approved drugs are covered. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.

Providence Health Plan (PHP) uses a prescription drug formulary for therapeutic drugs. Some drugs may require ***prior authorization*** by PHP.

If you need more detailed information about the drug formulary or drug coverage, including information on drugs requiring prior authorization, please visit **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** or call PHP Customer Service at 800-878-4445.

Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, number of doses or daily dose. Please have your provider contact PHP for prior authorization.

Tobacco Cessation Drug Therapy

Tobacco cessation drug therapy, including nicotine replacement therapy, is covered at 100% as a preventive drug when using a ***participating pharmacy***. ***Over-the-counter*** nicotine replacement gum and patches are included with physician's prescription. Plan-approved tobacco cessation programs are encouraged and included in your tobacco cessation benefit.

See **Medical and Pharmacy Benefits Exclusions** section for additional information.

Benefit Summary of Covered Medical Expenses – Oregon EPO Medical Plan

All services are subject to the **Medical and Pharmacy Benefit Exclusions** in addition to any service-type exclusions listed in the Benefit Summary

The following table describes the Oregon EPO medical plan benefits. For each benefit, the Plans pay a percentage of the covered amount depending on where you seek care.

Refer to Choosing a Provider for Oregon EPO Medical Plan Participants. This plan covers services from in-network providers only.

Benefit	EPO Medical Plan
Certain expenses do not apply to the ***out-of-pocket maximum***, including but not limited to: services not covered by the Plan (even if recommended by a physician/provider), services in excess of a maximum benefit limit or fees in excess of ***allowable charges***.	
Acupuncture	
May include ***medically necessary*** adjunctive therapy when provided with ***acupuncture*** course of treatment for neuro-musculoskeletal disorders, nausea or pain. For services provided by a licensed acupuncturist.	**Subject to the *deductible*.** **Office visits:** • Plan pays 80% of the covered amount, you pay remainder of the billed amount. Up to a maximum of 12 visits for acupuncture and spinal manipulations combined allowable in a ***Plan Year***. Limit does not apply to charges for office visits, lab or X-ray services. Amounts that apply to the ***deductible*** also apply to the benefit limit.
Allergy Services	
Allergy shots, allergy serum, injectable medications and total parenteral nutrition (TPN)	**Subject to the *deductible*.** **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%.
Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorder	
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 in the diagnosis of autism spectrum disorder. Benefits include coverage for any other non-excluded mental health or medical services identified in the individualized treatment plan.	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required.**

Benefit	EPO Medical Plan
ABA (Continued) An approved ABA treatment plan is subject to review and may be modified or discontinued if review shows that you or your covered dependent who is receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. Services may be provided in the member's home or a licensed health care facility. There are no visit frequency limitations.	
Exclusions: Services provided by a family or household member; services that are custodial in nature, or that constitute marital, family, educational or training services; respite care, creative arts therapy, social counseling, music therapy, chelation or hyperbaric chambers; services provided through community or social programs or an individual education plan in accordance with the Individuals with Disabilities Education Act; services provided by the Department of Human Services or other applicable state agency, other than employee benefit plans offered by the department and the authority.	
Cancer Screening and Non-Surgical Treatment	
Routine cancer screening • Covered as Preventive Services in accordance with the Adult Preventive Care schedule under the Plan and the Patient Protection and Affordable Care Act of 2010. • Mammogram: at any age • Prostate cancer screen: for one prostate specific antigen (PSA) or DRE per calendar year – beginning at age 40. • Colorectal cancer screening exam or tests for fecal blood test, flexible sigmoidoscopy, colonoscopy, barium enema – beginning at age 50 (under age 50, covered under Outpatient Surgery benefit).	**Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%.
Colonoscopy scheduled for other than screening exam, based on ***medical necessity***.	**Subject to the *deductible*.** **Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%.
Outpatient chemotherapy or radiation therapy	**Subject to the *deductible*.** **Facility and Physician/Provider** • Plan pays 80% of the covered amount, you pay 20%.
Clinical trials relating to cancer	**Subject to the *deductible* and *coinsurance*.**

Benefit	EPO Medical Plan
	Coverage is available under standard plan provisions for care provided by the health care practitioners associated with the clinical trial that would otherwise be covered (preventive services, diagnosis, treatment, palliative care). ***Prior authorization*** **may be required. Contact PHP to verify.**
Chemical Dependency	**See Mental Health and Chemical Dependency**
Chiropractic Services	
• Office visits for diagnosis, evaluation and treatment planning for musculoskeletal conditions • Related diagnostic x-rays and laboratory services for the diagnosis and evaluations of musculoskeletal conditions • 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 that are ***medically necessary*** for the treatment of neuro-musculoskeletal disorders, including one unit of massage therapy per visit when billed with manipulation	**Subject to the *deductible*.** **Any in-network licensed chiropractor:** Plan pays 80% of the covered amount for spinal manipulations, you pay the remainder of the billed amount. Up to a maximum of 12 visits for acupuncture and spinal manipulations combined allowable in a ***Plan Year***. Limit does not apply to charges for office visits, lab or X-ray services.
Exclusions: Services of a chiropractor which are not within the scope of practice, as defined by state law; charges for care not provided in an office setting; maintenance or preventive treatment consisting of routine long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.	
Dental Services and Dental Anesthesia	
Dental services received after an accidental ***injury*** to natural teeth, which occurred while covered under the Plan Conditions for receiving this benefit • For emergent treatment of dental trauma: When problem is diagnosed, and treatment plan delineated within 72 hours of trauma; and • For other corrective dental treatment following dental trauma: Need for corrective treatment must be identified and the treatment initiated within 12 months of dental trauma **Outpatient facility** charges and related anesthesia charges for dental services for children under age 7, developmentally disabled children or developmentally disabled adults (these services are not otherwise provided under the Medical Plan)	**Subject to the *deductible*.** **Professional Services:** • **In-network**: Plan pays 80% of the covered amount, you pay 20%. **Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Anesthesia:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required for all treatment, except emergency services.**

Benefit	EPO Medical Plan
Dental (Continued) Exclusions: Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth and/or gums, wisdom teeth, areas surrounding the teeth and dental implants), except as approved by Providence Health Plan.	
Diabetic Care	
Annual preventive exams • Dilated retinal exams by a qualified participating eye care specialist • Glycosylated hemoglobin (HbA1c) test • Urine test to test kidney function • Blood test for lipid levels as appropriate • Visual exam of mouth and teeth by a personal physician/provider or other provider (dental visits are not covered) • Foot inspection without shoes or socks NOTE: With the exception of the dilated retinal exam, all of the above may be performed in your provider's office at the time of your annual exam. The eye exam may be done by an eye care specialist. Exams may be performed more often than once a year if your provider decides they are ***medically necessary***. Additional exams and tests are subject to the ***deductible*** and ***coinsurance***.	**Annual preventive exams:** **Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. **Additional exams billed with a medical diagnosis:** **Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%.
Diabetes supplies (covered under **Preventive care** services) • Glucose control solution • Glucose monitoring supplies • Insulin pump supplies (including vials of pump-compatible insulin for Type 1 diabetes) • Lancets and lancet devices • Needles • Syringes • Test strips Note: Insulin pumps (which include OmniPod Insulin Management Systems) and blood glucose meters, readers and transmitters for continuous blood glucose monitors are covered under your ***durable medical equipment*** benefit.	**Not subject to the *deductible***. Plan pays 100% of the covered amount, you pay 0%.

Diabetes self-management education program Initial self-management education program. Your provider can recommend a specialist or facility that provides these services. You must be enrolled on the date services are received through the program for benefits to be paid.	**Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%.
Diagnostic X-ray and Laboratory Outpatient	
Diagnostic charges **for X-ray and laboratory services** • Allergy testing • Pre-admission testing (PAT) • Ultrasound Includes contrast materials (dyes) that may be required for a diagnostic procedure.	**Subject to the *deductible*.** **Facility:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required for high-technology radiological/imaging services such as MRI, MRA, SPECT CT, CTA and PET scans.**
Dialysis Outpatient	
Renal Dialysis	**Subject to the *deductible*.** **Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%.
Emergency and Urgent Care Services	
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. If you are admitted to a non-participating ***hospital***, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.	**Not subject to the *deductible*** $60 copay per visit; in-network only.

Emergency Care **(Hospital)** 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: • Acute abdominal pain • Bleeding that does not stop • Heart attack • Loss of consciousness • ***Medically necessary*** detoxification • Poisoning • Serious burn • Severe chest pain • Stroke • 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 for coverage to continue.	**Not subject to the *deductible*.** • **Facility:** You pay $250 ***copayment*** per visit, the Plan pays the remainder ***Copayment*** is waived if patient directly admitted from emergency room. **Physician/Provider:** • **In & Out of network:** Plan pays 100% of the covered amount.

An "Emergency Medical Condition" is a medical condition that manifests itself by 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 place the health of a person (or a fetus in the case of a pregnant woman) in serious jeopardy.

"Emergency Services" are those health care items and services furnished in an emergency department. Services include all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

Plan benefits cover Emergency Services in the emergency room of any ***hospital.*** Emergency department 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.

When you are admitted to an out-of-network ***hospital*** from the emergency room or an ***urgent care*** facility, your ***inpatient*** services are covered under your ***in-network*** benefit until your condition becomes stable. Once your condition is stabilized, PHP 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 PHP has determined that repatriation is medically appropriate, the additional days spent at the out-of-network ***hospital*** will not be covered.

Durable medical equipment Including expenses related to necessary setup, repairs, and maintenance. A statement is required from the prescribing physician/provider describing how long the equipment is expected to be necessary and whether the equipment is ***medically necessary***. This statement will determine whether the equipment will be covered and if covered whether rented or purchased. If approved for rental, the Plan will pay the equipment rental cost up to the purchase price of such equipment. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition, because of normal wear and tear, or because purchase of new equipment is less expensive than repair of existing equipment.	**Subject to the *deductible*.** Plan pays 80% of the covered amount, you pay 20%. * ***Prior authorization required*, including but not limited to:** • Diabetic insulin pumps/OmniPods/continuous blood glucose monitors • Select nerve stimulators • Flexion/extension devices • Oral appliances • Power wheelchairs and supplies • Rental of CPAP • Purchase of CPAP post-trial rental period (new ***prior authorization*** required prior to CPAP purchase) • Seat lift mechanisms • Skin substitutes • Speech generating devices • Wound therapy pumps *Diabetes supplies covered at 100%; not subject to the deductible
Exclusions: Includes but is not limited to: **Bed-related items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses. **Bath-related items**: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats and spas. **Chairs, lifts and standing devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer) and auto-tilt chairs. **Fixtures to real property:** ceiling lifts and wheelchair ramps. **Car/van modifications. Air-quality items:** room humidifiers, vaporizers, air purifiers and electrostatic **machines. Blood/injection-related items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors. **Other equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.	
Hearing aids **$1,500 benefit for hearing aids for both ears combined, every 36 months (rolling)** (See **Preventive Care** for Hearing Exam benefit)	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%.
Exclusions: Hearing aid batteries	

Other equipment and supplies • Medical devices that are surgically implanted into the body to replace or aid function: artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition or if replacement is less expensive than repair of existing prosthesis • Original fitting, adjustment, and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired (Replacement of such devices will be covered only if the replacement is necessary due to a change in the physical condition of the covered person or because of normal wear and tear.) • Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment • Orthopedic or corrective shoes and other supportive appliances for the feet when prescribed by a covered ***health care provider*** • Orthotics • Blood and/or plasma, and the equipment for its administration, including autologous blood transfer	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%. **Limits:** • Orthotics benefit limited to $500 in covered expenses every calendar year. • Jobst stocking limited to two pair per calendar year • Wigs (cancer and alopecia diagnosis only) $150 per calendar year limit; the deductible applies to the $150 limit.
Exclusions: Includes but is not limited to: prefabricated foot orthoses, cranial banding, cranial orthoses. Other similar devised are excluded except when used postoperatively for synostotic plagiocephaly; orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; orthoses primarily used for cosmetic rather than functional reasons; and orthoses primarily for improved athletic performance or sports participation.	
Family Planning	
Contraceptive services Includes over-the-counter contraceptives, spermicides or barrier devices.	Not covered by PH&S. Please contact Providence Health Plan directly for information on obtaining coverage for these items.
Female sterilization	Not covered by PH&S. Please contact Providence Health Plan directly for information on obtaining coverage for these items.
Male sterilization	Not covered.
Termination of pregnancy	Not covered.

Genetic Testing	
BRCA1 and BRCA2 mutation Testing must be specifically ordered by the treating physician. Genetic testing for BRCA1 and BRCA2 mutation, specifically included as a benefit, will be limited to once per lifetime. Coverage of this testing shall not be construed in any manner to be authorization for coverage of either prophylactic mastectomy or oophorectomy.	**Not subject to the *deductible*.** Plan pays 100% of the covered amount. ***Prior authorization*** **is required.**
Other genetic screening and counseling 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 and therapeutic in nature.	**Subject to the *deductible*.** • **In-network:** Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required for genetic testing.**
Exclusions: Genetic testing which does not provide a definitive diagnosis or risk classification OR which does not guide treatment decisions or clinical management, will be excluded and not covered.	
Home Health Care	
Up to 130 home health care visits per calendar year Each visit by a person providing services under a home health care plan or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care service is considered one home health care visit.	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%.
All ***covered services*** for home health care must be skilled services and do not include coverage for ***custodial care***. 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. Rehabilitation services provided under an authorized home health care plan will be covered as home health care services. Exclusions: charges for mileage or travel time to and from your home; wage or shift differentials for home health providers; charges for supervision of home health providers; or 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.	

Hospice Care	
Hospice care is a coordinated program of home care and inpatient care for a terminally ill patient, combined with support for the patient's family. The program provides for special needs arising from physical, psychological, spiritual, and economic stresses people experience during the final stages of a terminal illness.	**Subject to the *deductible*** • Plan pays 100% of the covered amount, you pay 0%.

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.
2. The ***covered services*** provided are reasonable and necessary for the condition and symptoms being treated.

Hospice care covered services and supplies include:

- Charges made by a ***hospice facility***, ***hospital***, or nursing facility, which are for:
  - Room and board and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management.
  - Services and supplies furnished to a person while not confined as a full-time inpatient.
- Charges made by a hospice care agency for:
  - Nursing care provided by ab R.N. or L.P.N,. these consist of caring for the person
  - Medical social services under the direction of a physician, including: assessment of the person's social, emotional and medical needs and the home and family situation; identification of the community resources which are available to the person; and assisting the person to obtain those resources needed to meet the person's assessed needs
  - Psychological and dietary counseling
  - Consultation or case management services by a physician
  - Physical and occupational therapy
  - Home health aide services; these consist mainly of caring for the person
  - Medical supplies
- Drugs and medicines prescribed by a physician
- Charges made by the providers below, but only if the provider is not an employee of a hospice care agency and such agency retains responsibility for the care of the person:
  - A physician for consultant or case management services
  - A physical or occupational therapist
- A ***home health care agency*** for:
  - Physical and occupational therapy
  - Home health aide services; these consist mainly of caring for the person
  - Medical supplies
  - Drugs and medicines prescribed by a physician
  - Psychological and dietary counseling

Exclusions: Any charge for daily room and board in a private room over the facility's semiprivate room rate; bereavement counseling; funeral arrangements; pastoral counseling; financial or legal counseling (including estate planning and the drafting of a will); homemaker or caretaker services (these are services not solely related to care of the person including: sitter or companion services for either the person who is ill or other members of the family, transportation, housecleaning, and maintenance of the house); respite care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Palliative Care Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information and choice.	Covered as any other benefit, by the medical service rendered.
Hospital and Specialized Facilities	
Hospital* – *inpatient* acute care, Inpatient rehabilitation** • Room and board, not to exceed the semi-private room charge. If a private room is the only accommodation available, the Plan will cover an amount equal to the hospital's average semi-private room rate. • ***Intensive care unit (ICU) and coronary care unit • Miscellaneous hospital services and supplies required for treatment during a hospital confinement	**Subject to the *deductible*.** **Inpatient, Acute Care Facility:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization* is required for all inpatient admissions.** For emergency admissions, Providence Health Plan must be notified within 48 hours or as soon as reasonably possible.
Skilled Nursing Facility No limit.	**Subject to the *deductible*.** **Skilled Nursing Facility:** • **In-network:** Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization* is required for all *skilled nursing facility/inpatient* admissions.** For emergency admissions, Providence Health Plan must be notified within 48 hours or as soon as reasonably possible.
Hospital – Outpatient Includes ***ambulatory surgical facility***, and ***birthing center***.	**Subject to the *deductible*.** **Outpatient Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%. **Some outpatient procedures require *prior authorization*. Contact PHP to verify if required**
Infertility	
Infertility Testing and Counseling Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when performed for the sole purpose of diagnosing. Diagnostic services include hysterosalpingogram, laparoscopy and pelvic ultrasound.	**Subject to the *deductible*.** **Facility and Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%. The maximum ***allowable charge*** for screening for infertility testing/counseling is $500 per calendar year. The ***deductible*** applies to the $500 limit.

Infertility Exclusions: treatment of infertility (including surgical); infertility related drugs or injectables; reversal of reproductive sterilization; artificial insemination including cost of acquiring semen; in vitro and in vivo fertilization or services supporting in vitro fertilization; services for non-member surrogate mother; all services associated with surrogate parenting; fees for surrogate parent; services, supplies, drugs, and procedures for reproductive disorders, defects, and/or inadequacies, whether or not the consequence of Illness, disease, or ***injury***; disorders, defects, and/or inadequacies shall include, but not be limited to: impotency, frigidity, infertility, sterility, and reversal of surgical sterilization.	
Infusion Therapy	
A type of care involving non-self-administered intravenous drugs. Infusion therapy is covered as any other medical service; refer to place of service.	**Subject to the *deductible*.** **Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%.
Maternity and Pregnancy	
Prenatal as preventive care, including obstetrical specialist for high-risk pregnancy. For amniocentesis and ultrasound services, see **Diagnostic x-ray and laboratory** benefit.	• **Not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%.
Delivery and postnatal care, including obstetrical specialist for high-risk pregnancy.	**Physician/Provider:** • Not subject to the ***deductible.*** Plan pays 100% of the covered amount, you pay 0%. For delivery facility, see **Hospital and Specialized Facilities** benefit.
Breastfeeding counseling and support Covered under the terms of the Plan and the Patient Protection and Affordable Care Act of 2010. Includes breast pump rental or purchase.	**Not subject to the *deductible*.** **Lactation Counseling** • Plan pays 100% of the covered amount, you pay 0%. **Equipment/Supplies** • Plan pays 100% of the covered amount for purchase of breast pump equipment and supplies at in-network providers, including retail outlets (e.g., Target). Plan pays 100% of heavy-duty hospital grade electric pump for the duration of breastfeeding.
Exclusions: Maternity expenses of non-member surrogate, services by a midwife unless licensed or certified nurse midwife or a nurse practitioner midwife, home and water births.	

Mental Health and Chemical Dependency	
Inpatient services Inpatient, residential, and day treatment or partial hospitalization for the treatment of mental or chemical dependency disorders, including detoxification must be obtained at an approved treatment facility. Non-emergency inpatient, residential and day treatment mental health and/or chemical dependency services are covered benefits only when prior authorized by Optum at 800-711-4577 under standards generally applied by Optum. Optum is available as a resource for outpatient services and will work with your ***qualified practitioner*** to coordinate your care. If you have concerns about the confidentiality of mental health or substance abuse treatment in an in-network facility, treatment elsewhere may be covered at the in-network rate, with ***prior authorization*** by Optum.	**Subject to the *deductible*.** **Inpatient Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Day Treatment Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Residential Services:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required.**
Outpatient Services Outpatient diagnostic evaluation and ***mental health treatment***, including individual and group therapy. Outpatient diagnosis and treatment for ***chemical dependency***. Treatment includes individual and group therapy. Optum, at 800-711-4577, is available as a resource for outpatient services and will work with your ***qualified practitioner*** to coordinate your care.	**Not subject to the *deductible.*** Plan pays 100% of the covered amount, you pay $0. **Certain services may require *prior authorization*. Call PHP to verify if required.**
Exclusions: Conditions other than mental or ***chemical dependency*** disorders specified in the current edition of the *Diagnostic and Statistical Manual of Disorders (DSM)*; services provided under a court order or as a condition of parole or probation; personal growth services, such as assertiveness or consciousness raising; treatments which do not meet the national standards for mental health or chemical dependency practice; counseling related to career treatments involving the use of methadone if such treatment is not part of a medically supervised treatment program that has been prior authorized by Optum; non-emergency inpatient, residential and day treatment, and all chemical dependency treatments if not prior authorized by Optum.	

Naturopathic Care	
Examination, clinical laboratory, diagnostic x-ray, office visit consultation, and/or adjunct therapy delivered by a naturopathic physician within a course of treatment that includes certain natural treatment methods, modalities, nutritional advice, recommendation of homeopathic protocols	**Subject to the *deductible*.** **Licensed naturopathic physician.** Plan pays 80% of the covered amount, you pay the remainder of the billed amount. See preventive care for these services when performed by a naturopathic provider.
Exclusions: Any services not within the scope of license to practice for a naturopathic physician, as defined by your state law. See **Medical and Pharmacy Benefits Exclusions** for additional services not covered by the plan for any practitioner.	
Newborn Care Inpatient	
Newborn services are covered separately from services for the delivering mother. Subject to the newborn being enrolled in medical coverage. Newborn nursery care is a facility service covered under your ***hospital*** services benefit. All other services provided to a newborn, including physician/provider services, are covered under the applicable benefit level.	**Not subject to the *deductible*.** **Facility:** • Plan pays 80% of the covered amount, you pay 20%.
Reminder: Coverage of newborns is not automatic. If you want to enroll the newborn, you must complete enrollment within 60 days of the date of birth (or date of placement for adoption), including required documentation. Contacting Providence Health Plan does not add the child to coverage.	
Nutrition	
Preventive nutritional counseling Nutritional counseling sessions in a calendar year for any diagnosis. No limit.	**Not subject to the *deductible.*** Plan pays 100% of the covered amount, you pay 0%.
Nutritional services Medical foods are covered for supplemental 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. Medical foods are defined as foods that are formulated to be consumed or administered internally under strict medical supervision for the treatment of inborn errors of metabolism.	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%. Approval of these services will be based on criteria established by Providence Health Plan and in accordance with regulatory requirements. ***Prior authorization*** **is required.**
Exclusions: Medical foods do not include total parenteral nutrition (TPN); this is covered under allergy shots, serums and injectable medications.	

Physician/Health Care Provider	
Primary care provider office visit for non-preventive services Can be a physician/provider specializing in family practice, internal medicine, general practice, obstetrics/gynecology or pediatrics. You can use a Providence retail clinic, e-visits or phone visits.	**Not subject to the *deductible*.** You pay $20 ***copayment*** per visit; the Plan pays 100% of the remainder of the covered amount.
Express Care Virtual visit With Express Care Virtual, you can receive virtual consultation from a licensed Providence primary care physician or nurse practitioner for common health conditions such as cough, cold, flu, headaches, eye infections or sinus infections using a computer, smart phone or tablet.	**Not subject to the *deductible*.** Plan pays 100%, you pay 0%.
Non-primary care provider/Specialist visit No referral required.	**Not subject to the *deductible*.** $40 copay
Inpatient hospital visit	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%.
Other office procedures, other professional services (radiology, pathology)	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%.
Prescription Drugs	
Prescription drugs	Please review the **Prescription Drugs** section for more information. Eligible prescription drug charges apply to the shared ***out-of-pocket maximum***.

Preventive Care	
Well-child care Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. Includes covered preventive care, including routine immunizations/shots for children under the provisions of the Patient Protection and Affordable Care Act. For more information: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/children** Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status.	**When billed as preventive care, not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. To receive in-network benefit, services must be provided by a primary care provider. Note: You may have out-of-pocket costs due to the ***deductible*** and/or ***copayment*** or ***coinsurance*** for the office visit if the preventive service is not the primary purpose of the visit or if your doctor bills you for the preventive services separately from the office visit.
Adult preventive care Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. Recommended guidelines for periodic exams: • Age 20 – 29: one exam every five years • Age 30 – 49: one exam every two years • Age 50 and older: one exam every year • Ancillary services, such as immunizations, are covered at the specified benefit levels when billed separately by the provider. Includes the covered preventive care services under the provisions of the Patient Protection and Affordable Care Act. For more information: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults**	**When billed as preventive care not subject to the *deductible.*** Plan pays 100% of the covered amount, you pay 0%. To receive in-network benefit, services must be provided by a primary care provider. You may have out-of-pocket costs due to the ***deductible*** and/or ***copayment*** or ***coinsurance*** for the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit. May be performed by naturopath.

Well-woman visit/women's preventive care Gynecological exams and Pap tests, (mammograms, see Cancer screening), and women's health preventive care and screenings supported by the Health Resources and Services Administration. Includes the covered preventive care services, including routine immunizations/shots, under the provisions of the Patient Protection and Affordable Care Act. For more information: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/women**	**When billed as preventive care, not subject to the *deductible*.** Plan pays 100% of the covered amount, you pay 0%. To receive in-network benefit, services must be provided by a primary care provider. You may have out-of-pocket costs due to the deductible and/or ***copayment*** or ***coinsurance*** for the office visit if the preventive service is not the primary purpose of the visit or if your doctor bills you for the preventive services separately from the office visit. May be performed by naturopath.
Laboratory services for preventive care Including, but not limited to, Pap smear, CBC, urinalysis, chemical profile, and glucose. For more information: **https://healthplans.providence.org/members/member-groups/phs-caregivers/make-the-most-of-your-benefits/**	**If billed with preventive diagnosis, not subject to the *deductible.*** Plan pays 100% of the covered amount, you pay 0%. **If billed with diagnosis other than preventive, subject to the *deductible*.** Plan pays 80% of the covered amount and you pay 20%.
Hearing Exam $250 maximum covered expenses per calendar year.	**Not subject to the *deductible.*** Plan pays 100% of the covered amount, you pay 0%.

Rehabilitative and Habilitative Services – Outpatient	
Short-term outpatient rehabilitative and habilitative services are covered up to 75 visits* per calendar year, all therapies combined (physical therapy, speech therapy, occupational therapy and neurodevelopmental therapy). Therapy is provided by physicians and/or licensed or registered therapists to restore or improve function lost due to illness or ***injury***. Benefits are limited to covered services that can be expected to result in the significant improvement of the condition. The treatment must be part of a written treatment plan prescribed by a qualified provider. This benefit includes treatment for Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder not otherwise specified. ***The 75-visit calendar-year limit does not apply to treatment of mental health conditions.**	**Subject to the *deductible*.** **Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **required for neuropsychological testing.**
Exclusions: Exercise programs; Rolfing, polarity therapy, and similar therapies and growth and cognitive therapies, including sensory integration and treatment of developmental delay except for diagnosed neurodevelopmental conditions.	
Sleep Disorders	
Treatment of sleep disorders and/or sleep studies Home sleep studies are also covered.	**Subject to the *deductible*.** **Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required.**
Exclusions: Services not having prior authorization by the Claims Administrator.	

Surgery and Anesthesia	
Surgeon's expenses for the performance of a surgical procedure, and the services of an assistant surgeon not to exceed 20% of the ***allowable charge*** of the primary surgeon or in accordance with PPO contract limits. Anesthesia, when administered by a licensed anesthesiologist or certified registered nurse anesthetist (C.R.N.A.) in connection with a surgical procedure.	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required for select surgical procedures. Contact PHP to verify if required.**
Breast reconstruction A covered person will be covered for all stages of one breast reconstruction/reduction on the non-diseased breast to make it equivalent in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed following a mastectomy. A prosthesis may be covered after a mastectomy if recommended by the treating physician following the mastectomy.	**Subject to the *deductible*.** (See the **Hospital and Specialized Facilities** benefit for facility coverage.) • Plan pays 80% of the covered amount, you pay 20% ***Prior authorization*** **is required.**
Coverage for breast reconstruction and related services will be subject to all applicable ***deductible***, ***copayments*** and ***coinsurance*** amounts that are consistent with those that apply to other benefits under the Plan. The Plan will at all times comply with the terms of the Women's Health and Cancer Rights Act of 1998 and will not deny a patient eligibility to enroll or to renew coverage, under the terms of the Plan, solely to avoid the requirements of this section. Additionally, the Plan will not penalize the patient or physician, or induce him or her to provide care to a participant in a manner inconsistent with this provision. Any Plan exclusions or limitations that exclude the benefit described above are hereby omitted to the extent that they specifically prohibit the above coverage.	
Reconstructive surgery **Correction of a congenital defect or congenital anomaly** To restore the anatomy and/or functions of the body which are lost or impaired due to an illness or ***injury***. Head/facial structures: restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including malocclusion of the jaw, when services are ***medically necessary*** for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing.	**Subject to the *deductible*.** (See the **Hospital and Specialized Facilities** benefit for facility coverage.) • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required for select surgical procedures. Contact PHP to verify if required.**
Exclusions: Cosmetic surgery (primarily to preserve or improve appearance); dental services including, but not limited to, orthodontia, tooth decay, impacted teeth; orthognathic surgery to shorten or lengthen jaw unless related to injury or neoplastic/degenerative disease.	

Temporomandibular Joint (TMJ) and Orthognathic Services	
A diagnostic examination including a history, physical examination and range of motion measurements, as necessary; diagnostic X-rays; physical therapy of necessary frequency and duration; therapeutic injections; surgery; therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite Coverage of the appliance/splint is under the provisions of this section. The benefit for the appliance splint therapy will include an allowance for diagnostic services, office visits and adjustments. Surgical services. Orthognathic services, including surgical treatment of TMJ, only when there is significant evidence of pathology as a result of illness or ***injury***. Illness refers to a neoplastic process, degenerative disease or infection.	**Subject to the *deductible*.** • Plan pays 80% of the covered amount, you pay 20%. The benefit is limited to $3,000 per lifetime. ***Prior authorization*** **is required for select surgical procedures. Contact PHP to verify if required.**
Exclusions: Dental or orthodontia services	
Tobacco Cessation	
Covered under the terms of the Plan and the Patient Protection and Affordable Care Act of 2010. Coverage is provided for participation in a PHP-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. Also includes participation in the Alere Quit for Life® Program.	**Not subject to the *deductible*.** Plan pays 100% of the covered amount; you pay 0%.

Transplants, Human Organ/Tissue	
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 participant) • From and replaced in the same person's body (a self-donor who is a participant) 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.	**Subject to the *deductible*.** **Inpatient Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Surgeon/Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization* is required.**

To qualify for coverage, all transplant-related services, procedures, treatment protocols, and facilities must have ***prior authorization*** by Providence Health Plan to be ***medically necessary*** and medically appropriate according to national standards of care, including initial consultation, evaluation, transplant facilities, donor evaluation, donor services, HLA typing, pre-transplant care, self-donation services, transplant services, and follow-up treatment.

NOTE: Prior authorization is not a treatment directive. The actual course of treatment that a participant chooses remains strictly a matter between the participant and their physician and is separate from the prior authorization requirements.

Covered Services:
Once ***prior authorization*** is received, ***covered services*** for transplants are limited to services that:

- Are provided at a facility that is in Providence Health Plan-credentialed Centers of Excellence or Providence St. Joseph Health affiliate transplant program
- Involve one or more of the following organs or tissues:
  - Allogeneic hematopoietic stem cell/bone marrow/cord blood
  - Autologous hematopoietic stem cell/bone marrow
  - Heart
  - Kidney
  - Liver
  - Lung
  - Pancreas
  - Small bowel
- 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 and high-dosage chemotherapy for stem cell/bone marrow/cord blood transplants.

Travel expenses	
Travel expenses require ***prior authorization*** and are available for either the recipient and one companion, or recipient and the donor for ***medically necessary*** services related to an approved transplant. Travel benefits are paid if the recipient is required to travel 100 miles each way or more from his or her home address for the medically necessary services related to an approved transplant, or if the facility requires the patient to remain within a certain distance of the facility during the transplant process.	**Subject to the *deductible*.** **Travel benefit** $250 per diem food and lodging; mileage reimbursement at federal IRS rates with minimum travel distance between home and provider of 100 miles each way. $5,000 lifetime maximum for travel expenses; food and lodging per diem applies to the $5,000 lifetime maximum for travel expenses. ***Prior authorization*** **is required.**
Exclusions: Charges for alcohol, tobacco, laundry, telecommunications, and transportation that exceed coach-class rates.	
Services for transplant donors Covered when both of the following apply: • The transplant recipient is a member of the Plan and is eligible for transplant benefits • The donor is not eligible for coverage of donation services under any other health benefit plan or government funding Covered services for donors include: • Initial evaluation of the donor and related program administration costs • Preserving the organ or tissue, transporting the organ or tissue to the transplant site • Acquisition charges for cadaver or live donor • Services required to remove the organ or tissue from the donor • 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	**Subject to the *deductible*.** **Inpatient Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Physician/Provider:** • Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required.**
Benefits for outpatient medications	Benefits for outpatient medications and antirejection (immunosuppressive) drugs are covered under the prescription drug benefits.
Exclusions: Any transplant procedure performed at a transplant facility that has not been approved by Providence Health Plan; any transplant that is ***experimental and investigational***, as determined by Providence Health Plan; services or supplies for any transplant that are not specified as ***covered services***, such as transplantation of animal organs or artificial organs; services related to organ/tissue donation by a member of the Plan 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.	

Transportation	
Ambulance Services for emergency medical transportation by state- certified ambulance and certified air ambulance transportation. Ambulance services are provided for transportation to the nearest facility capable of providing the necessary care or to a facility specified by Providence Health Plan.	**Subject to the *deductible*.** Plan pays 80% of the covered amount, you pay 20%. ***Prior authorization*** **is required for air ambulance services except in medical emergencies.**
Exclusions: Care cars, other medical transportation vehicles and other non-emergency medical transportation services; air ambulance transportation for non-emergency situations unless authorized by Providence Health Plan in advance.	
Travel Vaccinations and Related Medications	
Covered vaccines and related medications • Hepatitis A vaccine • Malarone • Bacillus Calmette-Guerin (BCG) vaccine • Rabies vaccine • Typhoid vaccine • Yellow fever vaccine • Diphtheria Toxoid vaccine • Cholera vaccine • Plague vaccine • Japanese encephalitis virus vaccine	**Not subject to the *deductible.*** **For immunizations:** • Plan covers services in full. **For travel counseling billed with immunization:** • Plan covers one travel counseling visit in full. **Travel immunizations do not require *prior authorization*.**
Weight Management	
Bariatric Surgery Coverage of open and laparoscopic Roux-en-Y Gastric Bypass surgery, Sleeve Gastrectomy and Biliopancreatic Bypass with Duodenal Switch for obesity is provided, along with other approved procedures, in accordance with medical policy and criteria established and maintained by Providence Health Plan.	**Subject to the *deductible*.** **Inpatient Facility:** • Plan pays 80% of the covered amount, you pay 20%. **Professional Fees:** • Plan pays 80% of the covered amount, you pay 20%. Benefits are limited to one bariatric procedure per lifetime. Must be ***medically necessary*** and performed at a designated facility. ***Prior authorization*** **is required.**
Travel expenses Travel expenses require preauthorization and are available for the surgical patient and one companion for medically necessary services related to an approved bariatric procedure. Travel benefits are paid if the recipient is required to travel 100 miles each way or more from his or her home address for the medically necessary services related to an approved bariatric procedure.	**Subject to the *deductible*.** **Travel Benefit:** $250 per diem food and lodging; mileage reimbursement at federal IRS rates with minimum travel distance between home and provider of 100 miles each way. $5,000 lifetime maximum for travel expenses; food and lodging per diem applies to the $5,000 lifetime maximum for travel expenses. ***Prior authorization*** **is required.**

Bariatric Surgery – Travel Expenses Continued Charges for alcohol, tobacco, laundry, telecommunications, and transportation that exceed coach-class rates are not covered.	
The surgery and related services, including complications, will be covered as any other medical condition and subject to applicable plan limits. Services to stabilize complications from previous bariatric surgery covered by the Plan will be subject to current plan provisions in place at the time of the complications.	
Exclusions: Open vertical banded gastroplasty; laparoscopic vertical banded gastroplasty; open and laparoscopic adjustable gastric band; gastric balloon; intestinal bypass surgery other than listed above and any procedure(s) associated with it; supplemental fasting; other treatments for obesity.	
Diabetes Prevention Program (DPP)	
Programs target: • Weight management/reduction, • Nutrition/eating habits, and • Activity • Approved in-network PHP partner programs include: — Omada — PREVENT — HMR	**Not subject to the *deductible*.** • Preventive service covered at 100% for employees, spouses, adult benefits recipients (ABR), or adult child over age 18, after eligibility is determined • Lifetime limit of two program sessions

Prescription Drugs – Oregon EPO Medical Plan

Benefit	Prescription Drugs – EPO Medical Plan
	Retail, preferred retail and mail-order pharmacies: Up to 90-day supply
Annual Deductible and Out-of-Pocket Maximum	
No deductible applies. Combined ***out-of-pocket maximum*** for medical care and prescriptions drugs under the EPO plan.	
Providence Pharmacies, Walgreens Pharmacies and Participating Pharmacies *	
Formulary ACA and Enhanced preventive generic and *brand drugs*	Plan pays 100% of the covered amount, you pay 0%
Generic drugs	You pay $10 per 30-day supply, the Plan pays the remainder.
Formulary *brand drugs*	**PSJH/Walgreens Pharmacies:** Plan pays 80% of the covered amount, you pay 20% up to a maximum of $75 per 30-day supply.
Non-formulary *brand-drugs*, including preventive drugs	**PSJH/Walgreens Pharmacies:** Plan pays 60% of the covered amount, you pay 40% up to a maximum of $125 per 30-day supply.
Specialty drugs	Plan pays 80% of the covered amount, you pay 20% up to a maximum of $200 per 30-day supply. Limited to a 30-day supply per fill. Medications must be purchased from Credena Health or a PSJH Facility.
Mail order (90-day supply) from designated mail-order pharmacy	Not all prescriptions are eligible for mail-order pharmacy. Your share of the cost is three times that of a 30-day supply as shown above, including three times the amount of the maximum for ***brand-name drugs***. See below "**Ordering Prescriptions by Mail**" for preventive prescription drugs requirement.
Non-Participating Pharmacy	
Not covered.	

* Not all areas will have a PSJH/Walgreens pharmacy available.

Contact Providence Health Plan (PHP) for more information regarding specialty medications, including which pharmacies must be used for coverage.

For the current formulary list, visit the Providence Health Plan website at **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** which also notes those medications considered preventive under the IRS definition or call PHP Customer Service at 1-800-878-4445.

ACA and Enhanced Preventive Drugs

Affordable Care Act (ACA) preventive drugs are generic or brand medications included on the Plan formulary and required to be covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.

A medication is considered preventive under the IRS definition when it is generally prescribed to prevent certain risks, complications or recurrence of a disease or condition. The enhanced preventive formulary does not include any drug or medication used to treat an existing illness, ***injury*** or condition, unless the drug or medication is prescribed to prevent an existing condition from worsening.

The preventive drugs covered by the plans administered by PHP are subject to formulary and tier status, as well as pharmacy management programs such as ***prior authorization***, step therapy and/or quantity limits. Refer to "**Ordering Prescriptions by Mail"** for additional information.

For the current formulary list of the generic and brand-enhanced preventive drugs, ACA preventive drugs and specialty drugs, visit the Providence Health Plan website at https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101 or contact PHP Customer Service at 1-800-878-4445.

Providence Health & Services sponsors your group health plan and has certified that it qualifies for a temporary enforcement safe harbor with respect to the Federal requirement to cover contraceptive services without cost-sharing. Please contact Providence Health Plan directly for information on obtaining coverage for these items.

Specialty Drugs

Specialty drugs are prescriptions that are injectable, infused, oral or inhaled therapies that require specialized delivery, handling and administration, and are generally high cost.

These drugs must be purchased through Credena Health. ***Specialty drugs*** are indicated on the PHP formulary list as "Specialty" in the status column. To view the formulary, visit **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** or contact the Customer Service at 1-800-878-4445.

Self-injectable drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration, and are on the Plan formulary. ***Prior authorization*** is generally required for the drug.

Using a Participating Pharmacy

Your prescription drug benefit requires that your prescriptions be filled at pharmacies that participate with Providence Health Plan. A list of the ***participating pharmacies*** is available on the website at **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** You also may contact PHP Customer Service at 1-800-878-4445 if you need help locating a participating pharmacy near you or when you are away from your home.

Please present your identification card at the ***participating pharmacy***. You may purchase up to a 90-day supply of each maintenance drug at one time using a preferred retail pharmacy or participating mail order pharmacy after an initial 30-day supply fill of the drug. See the **Prescription Drug** table above for ***copayments/coinsurance*** information.

Normally, diabetes supplies and inhalation spacer devices are obtained from a ***durable medical equipment*** (DME) supply house and the DME provisions apply. However, for your convenience, diabetes supplies and inhalation spacer devices may be obtained at your ***participating pharmacy***.

Ordering Prescriptions by Mail

Participating mail-order pharmacy information is available on the Providence Health Plan website at **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** or by calling PHP Customer Service at 1-800-878-4445. Your physician or provider may call in the prescription, or you can mail your prescription to a ***participating pharmacy***.

Not all prescription drugs are available by mail order. Providence Health Plan determines which drugs qualify for purchase by mail.

If your prescription is eligible, you may purchase up to a 90-day supply of each maintenance medication. See the **Prescription Drug** table above for ***copayments/coinsurance*** information.

Enhanced preventive prescription drugs on the PHP formulary drug list that are covered at 100% must be obtained through PHP's designated mail order pharmacy. You may receive your first two refills at a network retail pharmacy; however, after those two fills, participants must use the designated mail order pharmacy to be covered by the medical plan.

If you have existing prescriptions at another pharmacy and would like to transfer them to the participating mail-order pharmacy, contact the mail order pharmacy directly. We recommend that you order refills approximately two weeks before you expect to run out of your current supply of medication. Payment is required before your order is processed. If there is an important change in the participating mail-order pharmacies, you will be notified at least 30 days in advance.

Use of Non-Participating Pharmacies

Urgent or emergency medical situations may necessitate the use of a non-participating pharmacy. If this occurs, you will need to pay full price for your prescription at the time of purchase. You may be reimbursed by the Plan upon submission of a Prescription Drug Reimbursement Request form, which can be obtained from the website at **https://healthplans.providence.org/members** or by contacting PHP Customer Service at 1-8700-878-4445 and requesting one be sent to you. After you have completed and signed the form, submit it, along with your itemized pharmacy receipts, to the address listed on the form. Once received, your claim will be reviewed (submission of a claim does not guarantee payment). If your claim is approved, you will be reimbursed the cost of your prescription, subject to Plan benefits and limitations, less your applicable ***copayment***, or ***deductible*** and ***coinsurance.***

Quantities

- Prescription dispensing limits:
  - Opioids up to 7 days initial dispensing
  - Topical, up to 60 grams
  - Liquids, up to eight ounces
  - Tablets or capsules, up to 100 dosage units
  - 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.
  - Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. ***Prior authorization*** is required for amounts exceeding any applicable medication dispensing limits.
- Drugs or hormones to stimulate growth are covered only if there is a laboratory-confirmed diagnosis of growth hormone deficiency. These drugs are covered only for children under age 18 and for adults only if there is documented pituitary destruction and the drug use meets the medical policy criteria.
- Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount and must meet PHP's medical necessity criteria and be purchased at a participating pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered.

- Specialty drugs are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). In rare circumstances, specialty medications may be filled for greater than a 30-day supply. In these cases, an additional specialty cost share may apply.

Approved Drugs – Limitations and Prior Authorization

All drugs must be FDA-approved, ***medically necessary*** and require, by law, a prescription to dispense. Not all FDA-approved drugs are covered. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.

Providence Health Plan (PHP) uses a prescription drug formulary for therapeutic drugs. Some drugs may require ***prior authorization*** by PHP.

If you need more detailed information about the drug formulary or drug coverage, including information on drugs requiring prior authorization, please visit **https://www.providencehealthplan.com/providence-health-and-services-caregivers/benefits-101** call PHP Customer Service at 1-800-878-4445.

Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, number of doses or daily dose. Please have your provider contact PHP for prior authorization.

Tobacco Cessation Drug Therapy

Tobacco cessation drug therapy, including nicotine replacement therapy, is covered at 100% as a preventive drug when using a ***participating pharmacy***. ***Over-the-counter*** nicotine replacement gum and patches are included with physician's prescription. Plan-approved tobacco cessation programs are encouraged and included in your tobacco cessation benefit.

Medical and Pharmacy Benefits Exclusions

Medical Benefits Exclusions

In addition to the Plan exclusions (not covered expenses) previously listed in the tables in the **Benefit Summary of Covered Medical Expenses** and pharmacy sections, the Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician.

This list is intended to give you a general description of expenses for services and supplies not covered by the Plan.

- Expenses exceeding the ***allowable charge*** for the geographic area in which services are rendered
- Expenses not necessary for diagnosis of an ***illness*** or injury, except as specified under "Preventive Care"
- Treatment not prescribed or recommended by a physician or other covered ***health care provider***
- Drugs, procedures, treatments, services, supplies and/or devices that are not ***medically necessary*** or are not provided in accordance with Providence Health Plan ("PHP") policy
- Services or supplies for which there is no legal obligation to pay or expenses which would not be made except for the availability of benefits under this Plan
- ***Experimental and investigational*** drugs, treatments, devices, services and/or supplies
- Services furnished by or for the United States Government or any other government, unless payment is legally required
- Any ***injury*** or illness that is sustained by you or covered family member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for you or your covered family 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 applies even if you waive your rights to those benefits or chose not to participate in them. This exclusion does not apply to covered persons who are exempt under any Workers' Compensation Act or similar law.
- Services that 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. If such coverage is required by law and you fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement.
  - Any benefits or services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive the Plan's right to reimbursement or subrogation as specified under the **Third-Party Liability** section. This exclusion also applies to services and supplies after you have received proceeds from a settlement as specified in the **Benefits Paid by Other Sources** section.
- Educational, vocational, or training services and supplies including, but not limited to, videos and books, educational programs to which individuals are referred by the judicial system and volunteer mutual support groups
- Expenses for missed appointments or telephone calls, except as described in phone visits
- Travel expenses of a physician or a covered person, except as approved by PHP and specified in "Transplants, Human Organ/Tissue" and "Weight Management" and "Transportation".
- Services for immunizations or vaccinations for employment, licensing and high-risk occupations
- Sanitarium, rest or ***custodial care***
- Expenses eligible for consideration under any other plan of the employer
- Treatment or services rendered outside the United States of America or its territories except for an urgent medical condition or a ***medical emergency***
- Dental services or treatment, except as a result of accidental injury or as specified in Dental Services and Dental Anesthesia for dental services (except when approved by PHP to safeguard the health of the patient)

- Personal comfort or service items while confined in a ***hospital***, such as, but not limited to, radio, television, telephone, and guest meals
- Complications arising from any non-covered services, with the exception of ***emergency care***
- ***Cosmetic services***, including supplies and drugs, except as approved by PHP and stated in Surgery and Anesthesia
- Human organ and tissue transplants, except as stated in Covered Medical Expenses
- Expenses related to insertion or maintenance of an artificial heart
- Penile prosthetic implant
- Services related to the diagnosis and treatment of sexual dysfunctions or addiction
- Treatment of infertility (surgical or other) including fertility drugs
- Male reproductive sterilization, including reversal, spermicides, over-the-counter contraceptives
- Female reproductive sterilization reversal or over-the-counter contraceptives. Please contact Providence Health Plan directly for information on coverage.
- Intrauterine devices (IUDs) and implantable contraceptives. (Some of these items may be covered under your medical benefits. Please contact Providence Health Plan for more information or refer to the Benefit Summary).
- Services of homeopaths; faith healers; or lay/unlicensed direct entry midwives
- 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
- Routine vision exams and the fitting of eyeglasses or lenses orthotics or supplies
- Massage therapy or Rolfing
- Care cars, other medical transportation vehicles and other non-emergency medical transportation services are not covered.
- Expenses for education, counseling, job training or care for learning disorders or behavioral problems in the absence of a current DSM diagnosis, except as provided for neurodevelopmental therapies under the rehabilitative and habilitative services – outpatient benefit, whether or not services are rendered in a facility that also provides medical and/or mental health treatment
- Treatment, instructions, activities or drugs for weight reduction or control, except as stated in Weight Management
- Adoption expenses
- Surrogacy expenses
- Treatment of metatarsalgia or bunions, except for open cutting operations; corns, calluses or toe nails, except for removal of nail roots
- Non-surgical treatment for, or prevention of, temporomandibular joint dysfunction (TMJ) and craniomandibular disorder and other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint, except as stated in TMJ and Orthognathic Services
- Biofeedback (This exclusion does not apply to Mental Health Covered Services)
- Hypnosis
- Sleep studies and treatment of sleep disorders unless prior authorized by PHP as ***medically necessary***
- Wigs and artificial hair pieces except as stated in ***Durable Medical Equipment***
- Non-prescription drugs or medicines
- Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an illness or ***injury***
- A service or supply furnished in connection with or during a hospital stay of a person incurred:
  - Before effective date of coverage
  - After termination of coverage even if the confinement began while the person was insured by the Plan
- Services and supplies received under any state law, including physician aid in dying (physician-assisted suicide) benefits.

- Services which are self-administered (except as otherwise noted as covered), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. “Member of your family” for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or Adult Benefits Recipient of you or of any such person
- 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
- Spinal manipulation and ***acupuncture,*** except as otherwise noted as covered
- Ending of pregnancy unless consistent with the *Ethical and Religious Directives for Catholic Health Care Services Part 4 (fifth edition)*; non-permitted:
  - Abortion: the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus
- Services in excess of the benefit limits listed in the **Benefit Summary of Covered Medical Expenses**
- Services provided while in the custody of any law enforcement authorities or incarcerated
- Expenses related to any condition sustained by a covered 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)
- Any condition, disability or expense sustained as a result of the following; this exclusion does not apply if the ***injury*** results from an act of domestic violence or a medical condition (whether physical or mental):
  - Intentional or accidental atomic explosion or other release of nuclear energy (whether in peacetime or wartime)
  - Participation in a riot or civil revolution
  - Service as a member of the armed forces of any state or country
  - War or an act of war, whether declared or undeclared

*Exclusions that apply to Mental Health and **Chemical Dependency** Services:*

- 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, home-based behavioral management, household management training, peer support services, recreation, tutor and mentor services; independent living services, therapeutic foster care, wraparound services; emergency aid for household items and expenses; services to improve economic stability and interpretation services
- Exception: as part of applied behavioral analysis (ABA), the medical plans cover school counseling and support services and home-based behavioral management.
- 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, motor skill disorders, and educational speech delay, including delayed language development
- Counseling not provided to treat a mental health or chemical dependency diagnosis, such as family, marriage, or career counseling, is not covered

- Neurological services and tests including, but not limited to, EEGs; PET, CT and MRI imaging services and beam scans, except as provided by the Plan
- Services related to the treatment of sexual dysfunctions or addiction
- Vocational, pastoral or spiritual counseling
- Dance, poetry, music or art therapy, except as part of an approved treatment program
- Treatments that do not meet the national standards for Mental Health/Chemical Dependency professional practice

*Exclusions that apply to **Durable Medical Equipment**:*

- Bed-related items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment or mattresses
- Bath-related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats and spas
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer) and auto-tilt chairs
- Fixtures to real property: ceiling lifts and wheelchair ramps
- Car/van modifications
- Air-quality items: room humidifiers, vaporizers, air purifiers and electrostatic machines
- Blood/injection-related items: blood pressure cuffs, centrifuges, nova pens and needless injectors
- Other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines

The following services are excluded from all alternative care providers (acupuncturist, chiropractor, naturopathic physician):

- Alternative care services not stated as a covered service
- Preventive care and women's health services (except for certain services which are allowable when provided by naturopathic physician)
- Hypnotherapy, behavior training, sleep therapy and weight programs
- Education programs, self-care or self-help programs or any self-help physical
- Training or any related diagnostic testing
- Massage therapy
- Therapeutic modalities and procedures that are considered by Providence Health Plan or their authorizing agent to be invasive
- ***Emergency care*** and ***urgent care*** services
- Transportation costs including local ambulance charges
- Any service or supply that is not within an alternative care provider's scope of license to practice in that state.

Pharmacy Benefits Exclusions

- Drugs or prescribed medications that are not ***medically necessary*** or are not provided according to Providence Health Plan's medical policy
- Drugs that are not provided in accordance with Providence Health Plan's formulary management program
- Drugs for weight loss or cosmetic purposes
- Drugs or medications prescribed that do not relate directly to the treatment of a covered illness or ***injury***
- ***Over-the-counter*** (OTC) drugs (except for nicotine replacement gum and patches), medications or vitamins, that may be purchased without a provider's written prescription
- Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form

- Devices, appliances, supplies, and ***durable medical equipment***, even if a prescription is required for purchase. Some of these items may be covered under your medical benefits
- Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in a therapeutic amount
- Drugs used in treatment of fungal nail conditions
- ***Experimental or investigational*** drugs or drugs used by a covered person in a research study or in another similar investigational environment
- Drugs or medications delivered, injected or administered to you by a physician or other provider
- Herbal supplements and natural medicines prescribed by naturopathic physicians (N.D.) or other providers
- Dietary and nutritional supplements, including vitamins, herbs, herbals and herbal products, injectable supplements and injection services or other similar products
- Amphetamines and amphetamine derivatives, except when used in treatment of narcolepsy or hyperactivity in children and adults
- Methadone for pain management is covered. Methadone for the treatment of ***chemical dependency*** may be covered under the ***chemical dependency*** benefit of the medical benefits
- Drugs used for the treatment of impotence or sexual dysfunctions, regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services.
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions
- Insulin pumps (these are eligible for coverage under your ***durable medical equipment*** benefit)
- Preventive drugs on the PHP formulary not obtained through the designated mail order pharmacy after the first two fills
- Injectable medications unless they are intended for self-administration, labeled by the FDA for self-administration and on the Plan formulary
- Drugs used for the treatment of fertility/infertility
- Drugs which act as, or which under the Ethical and Religious Directives for Catholic Health Care Services Part 4 (fifth edition) are considered to act as, abortifacients
- Fluoride, for covered persons over the age of 16 years old
- Replacement of lost, stolen, or damaged medication
- Drugs to stimulate hair growth, including, but not limited to, Rogaine (i.e. topical minoxidil) or other similar drug preparations
- Prenatal vitamins that contain docosahexaenoic acid (DHA)
- Drug kits, unless the product is available only as a kit
- Drugs used for the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia
- Drugs placed on prescription-only status as required by state or local law
- Drugs that are not FDA-approved or designated as “less than effective” by the FDA, also known as a “DESI” drug
- Drugs prescribed under any state’s Death with Dignity Act or physician-assisted suicide law
- Contraceptive devices, cervical sponges, diaphragms, spermicides and other over-the-counter contraceptives even with a physician’s prescription. Please contact Providence Health Plan directly for information on obtaining coverage for these items.
- Drugs placed on prescription-only status as required by state or local law.
- Tobacco use deterrent medications except as covered under your medical benefit.
- Compounded drugs from bulk powders that are not a component of an FDA-approved drug

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials.

ACO Network
In-network preferred providers consisting of all Providence and St. Joseph Health facilities, medical groups and clinics and select provider partners.

Accident
An unforeseen and unavoidable event resulting in an injury, which is not due to any fault of the covered person.

Acupuncture
A technique of inserting and manipulating needles into “acupuncture points” on the body. According to acupunctural teachings, this will restore health, and is particularly good at treating pain.

Allowable charge
For any given covered service or supply, allowable charge is the amount an in-network provider or facility has agreed to accept as payment in full pursuant to applicable agreements between the contracting network and/or its administrator and the provider or facility.

Allowable charges will never be less than the negotiated fees.

When a covered service or supply is provided by an out-of-network provider or facility, the allowable charge is determined by the contracting network and/or its administrator and will generally be based on the network administrator or claims administrator’s methodology of allowable charge, unless a different allowable charge is required by applicable state law.

When services are provided by an out-of-network facility, the allowable charge is determined based upon a percentage of the Centers for Medicare and Medicaid Services (Medicare) fee schedules in the following categories: Hospital inpatient 218%; Hospital outpatient and all other services 212%; Ambulatory surgical center: 208%; Free standing lab 150%; Urgent/Emergent: 275%. For services in which a Medicare rate is not available, 47% of billed charges is the allowable charge.

When services are provided by an out-of-network provider**,** the allowable charge is determined based upon a usual and customary rate (UCR). The lesser of: (1) an amount that is no less than the lowest amount the network administrator pays for the same or similar service from a comparable provider under contract; (2) 125% of the Medicare fee schedule, if available; (3) the providers’ billed charges. Note: Ambulances are paid based on billed charges.

Emergency Care:
Consistent with the requirements of the Affordable Care Act, the Allowed Amount will be the greatest of the following amounts:
a. The median amount that Network Administrator's Network Providers have agreed to accept for the same services
b. The amount Medicare would allow for the same services
c. The amount calculated by the same method used to determine payment to Providers that don't have a contract with the Network Administrator.

Allowable charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Ambulatory surgical facility
A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of physicians, maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures, and supply registered professional nursing services whenever a patient is in the facility.

Benefits-eligible
If you work the amount of hours required, in a position designated as benefits-eligible by the Providence Health & Services, you receive certain core benefits and may make elections to enroll in other benefits at specified periods.

Birthing center
A public or private facility, licensed and operated according to the law, used to provide services and/or supplies associated with childbirth.

BlueCard Program
Under the BlueCard Program, you can receive ***covered services*** from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, also called the "Host Blue". Note: Oregon – based caregiver have access to a separate wrap network through Providence Health Plan for services received outside Oregon.

Brand Drug
Brand drugs are typically protected by U.S. patent laws and customarily only a single manufacturer has the rights to produce and sell them.

Chemical dependency
A 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.

Chemical dependency treatment facility
A public or private facility licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of substance abuse; detoxification services; infirmary-level medical services; supervision by a staff of physicians; and skilled nursing care by licensed nurses who are directed by a full-time R.N. The facility must also prepare and maintain a written plan of treatment for each patient based on medical, psychological and social needs.

Chiropractic services
The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebral) column.

Claims Administrator
A third party administrator or insurer designated by the plan administrator or its delegate to review and process claims for benefits under the Plan

Coinsurance
Coinsurance percentages represent the portions of covered expenses the Plan pays, or you pay after satisfying any applicable deductible. These percentages apply only to covered expenses which do not exceed allowable charges. You are responsible for the deductible, if any, coinsurance, all non-covered expenses, and any amount which exceeds the allowable charge for covered expenses.

Eligible expenses are paid by the Plan at the percentages shown on the following pages and vary depending on whether you receive your care from an in-network or out-of-network provider.

Coordination of Benefits
A clause included in health plans to determine the order of responsibility for benefits when a participant or dependent has coverage under more than one plan.

Copayment (copay)
A copayment is a flat dollar amount you pay for covered medical services when provided by an in-network provider. The Plan pays the rest of the cost for medical services up to plan limits for expenses which do not exceed allowable charges. (There are no copayments under the HSA Medical Plan.)

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:

- Listed as a benefit in the Benefit Summary
- Medically necessary
- Not listed as an exclusion; and
- Provided to you while you are a covered person and eligible for the service under the Plan

Custodial care
Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines or other services that can be provided by persons without the training of a health care provider.

Deductible
The deductible is the amount you must pay before the Plan pays any benefits. For the **HRA Medical Plan**, as each individual pays for covered care, it counts toward their individual deductible and the family deductible. When the individual deductible is met, the Plan begins paying its share of the cost for that individual's care. Once your family deductible is met additional individual deductible payments are not required for services to be covered in the Plan Year. For the **HSA Medical Plan**, if family coverage is elected, the family deductible must be met before the Plan pays benefits on any covered member of your family during the Plan Year. For the Oregon **EPO Medical Plan**, there is no annual deductible.

Diagnostic charges
The allowable charges for x-ray or laboratory examinations made or ordered by a physician in order to detect an existing medical condition.

Dual coverage
If you and your spouse or Adult Benefits Recipient (ABR) or a parent and an adult child are both employed by Providence and eligible for benefits, it is considered dual (duplicate) coverage, and therefore not permitted under the plan (medical, dental, vision) for both individuals to cover each other.

Durable medical equipment
Equipment which is medically necessary and recognized by the medical profession as being a viable therapeutic device which is able to withstand repeated use for the therapeutic treatment of an active illness or injury. Determinations of medical necessity will be made in accordance with Medicare/DSHS coverage guidelines. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

Eligible expenses
Charges for health care services or supplies that are covered under the Plan.

Emergency care
Emergency medical condition is a medical condition that manifests itself by 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
- With respect to a pregnant woman who is having contractions, there is inadequate time to effect a safe transfer to another hospital before delivery or 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
- Such further medical examination and treatment as required under 42 U.S.C. 1395dd, the Emergency Medical Treatment and Active Labor Act (EMTALA), to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the hospital

Experimental/Investigational (investigative)
Services that are determined by the Claims Administrator (Providence Health Plan) not to be medically necessary or accepted medical practice in the service area, including services performed for research purposes. In determining whether services are experimental/investigational, the Claims Administrator will consider whether the services are in general use in the medical community in the U.S.; whether the services are under continued scientific testing and research; whether the services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies.

The Claims Administrator determines on a case-by-case basis whether the requested services will result in greater health benefits than other generally available services, and will not approve such a request if the service poses a significant risk to the health and safety of the covered person. The Claims Administrator will retain documentation of the criteria used to define a service deemed to be experimental/ investigational and will make this available for review upon request.

Generic drugs
When a brand-name drug's patent expires, generic versions of the drug can be approved for sale. A generic drug works like a brand-name drug in dosage, strength, performance and use – and must meet the same quality and safety standards. All generic drugs must be reviewed and approved by the Food and Drug Administration (FDA).

Health care provider
A physician, practitioner, nurse, hospital or specialized facility as those terms are specifically defined in this section.

Home health care agency
A public or private agency or organization, licensed and operated according to the law that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one physician and one registered graduate nurse to supervise the services provided.

Hospice care
A program approved by the attending physician for care rendered to a terminally ill covered person with a medical prognosis that life expectancy is six months or less.

Hospice facility
A public or private facility, licensed and operated according to the law, primarily engaged in providing palliative, supportive and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six months or less. The facility must have an interdisciplinary medical team consisting of at least one physician, one registered nurse, one social worker, one volunteer, and a volunteer program. It must be approved by Medicare or accredited by the Joint Commission on Accreditation of Health Care Organizations. A hospice facility is not a facility or part of a facility which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital
An institution operated as required by law, which:
- Is primarily engaged in providing health services on an inpatient basis for the acute care of sick or injured patients; care is provided through medical, mental health, chemical dependency, diagnostic and surgical facilities, by or under the supervision of a staff of physicians
- Has 24-hour nursing services

Host Blue
The local Blue Cross and/or Blue Shield Licensee who is responsible for services such as contracting and handling substantially all interactions with its network providers. (Does not apply to the Oregon EPO Plan). Refer to the **Medical** chapter and provider section where Host Blue is described in further detail.

HR Service Portal
Electronic resource for benefits information available at **hrforcaregivers.org**. Health and welfare benefit elections can be entered by selecting the Benefits – enroll, review or update (BenefitConnect) link on the homepage under **External Links**. Access to the Benefits Service Center for questions is also available by navigating to **Request HR Help > Benefits > Benefits Questions**. Other HR tools and resource materials are available on the portal.

Injury
Under the medical plan, a condition which results independently of an illness and all other causes and is a result of an externally violent force or accident.

In-network
In-network means the level of benefits specified in the benefits summary for covered services provided by in-network providers.

In-network provider
An in-network provider (also referred to as preferred) means an outpatient surgical facility, home health provider, hospital, qualified practitioner, qualified treatment facility, skilled nursing facility or pharmacy that has a written contract with a network administrator or Claims Administrator to participate as a health care provider for this plan at specific, pre-negotiated rates. Typically, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

Inpatient
Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit
A section, ward or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate nurses or other highly trained personnel. This excludes, however, any hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Maintenance medication
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Compounded and specialty medications are excluded from this definition; and are limited to a 30 day supply.

Medical emergency
A sudden and unexpected illness and/or injury that you believe would place you in danger or cause serious damage to your health if you don't seek immediate care. Such conditions include, but are not limited to: suspected heart attack, stroke, loss of consciousness, respiration problems, actual or suspected poisoning, serious burn, heat exhaustion, convulsions, bleeding that does not stop, and acute chest pain or abdominal pain.

Medically necessary (medical necessity)
Medically necessary means services that are in the reasonable opinion of the Claims Administrator, Providence Health Plan, consistent with the written criteria regarding medically indicated services that are maintained by them. The criteria are based on the following principles.

The criteria are based on the following principles:

- The service is medically indicated according to the following factors:
  - The service is necessary to diagnose or to meet the reasonable health needs of the covered person
  - The expected health benefits from the service are clinically significant and exceed the expected health risks by a significant margin
  - The service is of demonstrable value and that value is superior to other services and to the provision of no services

Expected health benefits can include:

- Increased life expectancy
- Improved functional capacity
- Prevention of complications
- Relief of pain
- The qualified practitioner recommends the service and it meets other medical necessity criteria
- The service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient
- The service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Providence Health Plan

In the case of a life-threatening illness, a service that would not meet the criteria above may be considered medically necessary for purposes of reimbursement, if:

- It is considered to be safe and effective, as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition

For the purpose of this exception, the term “life-threatening” means more likely than not to cause death within one year of the date of the request for diagnosis or treatment. Any service or supply that is not experimental or investigational and that is required for the diagnosis or treatment of an active illness or injury, is rendered by or under the direct supervision of the attending physician, is appropriate and consistent with the diagnosis, is generally accepted by medical professionals in the United States, and which could not be omitted without adversely affecting the patient’s medical condition or quality of medical care. Drugs, procedures, treatments, services, supplies, and/or devices which are primarily for research or data accumulation, for custodial care, or for the convenience of the patient, the patient’s family, or of the provider of services or supplies and/or which are experimental and/or investigational in nature are not covered.

Mental health treatment facility

A public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of mental health disorders; infirmary-level medical services; supervision by a staff of physicians; and skilled nursing care by licensed registered nurses or by licensed practical nurses who are directed by a full-time R.N. It must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The facility must also prepare and maintain a written plan of treatment for each patient. The Plan must be based on medical, psychological, and social needs.

Nurse

Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), or Licensed Practical Nurse (L.P.N.).

Open enrollment

A defined time period when you and all other eligible employees are allowed to enroll yourself and/or your dependents for benefit coverage and make desired changes.

Out-of-network

Out-of-network means the level of benefits specified in the benefits summary for covered services provided by out-of-network providers.

Out-of-network provider

An 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 contract with a network administrator or a contract with the Claims Administrator to provide services for specific pre-negotiated rates, or is defined by the Plan to be out-of-network. Health plans may offer coverage for out-of-network providers, but your financial responsibility will be higher than it would be if you were seeing an in-network provider.

Out-of-pocket maximum

The maximum amount (including deductible) you must pay toward covered medical expenses in any Plan Year. After you have spent the out-of-pocket maximum, the medical option pays 100% of any additional covered expenses in that year.

Outpatient

Treatment either outside of a hospital setting or at a hospital when room and board charges are not incurred.

Outpatient mental health or chemical dependency service

Outpatient service means diagnosis or treatment of a person who is not an inpatient of a health facility or participating in a residential facility program. Outpatient service must be provided as part of a program approved by the State Mental Health Division or by one of the following:

- Physician
- Psychologist
- Psychiatrist
- Nurse Practitioner
- Licensed Clinical Social Worker (L.C.S.W.) upon the written referral of a physician or psychologist
- Certified Mental Health Counselor
- Social Worker (M.S.W.)
- Any other provider who is qualified to provide such services under their scope of license as defined by applicable state law.

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:

- **Retail:** a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions
- **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
- **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.
- **Mail Order:** a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your preferred location.

Physicians, surgeons, and dentists

Under the medical or dental plans, a person acting within the scope of their license and holding one of the following degrees, and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Optometry (O.D.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Dental Medicine (D.M.D.)
- Doctor of Podiatry (D.P.M., D.S.P. or D.S.C.)
- Doctor of Naturopathy (N.D.)
- Doctor of Chiropractic (D.C.)

For the purposes of the Plan, the term does not include you, your spouse, the immediate family of either you or your spouse or a person living in your household, including an Adult Benefits Recipient. Note: It is not guaranteed that providers holding all of the degrees or specialties are available as part of the network.

Plan Year

The 12-month period beginning January 1 and ending December 31.

Preventive drugs

ACA: Generic or brand-medications included on the Plan formulary, and required to be covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.

Enhanced Preventive (compliance with IRS Safe Harbor): Medications included on the Plan formulary that may prevent the onset of a disease or condition when taken by a person who has developed risk factors for the disease or condition that has not yet manifested itself or has not become clinically apparent, or may prevent the recurrence of a disease or condition from which a person has recovered. Enhanced preventive does not include drugs or medications used to treat an existing illness, injury or condition, unless the drug or medication is prescribed to prevent an existing condition from worsening.

Primary Care Physician (PCP)/Personal Physician/Provider (PPP)

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.
Enrolled adult females also may 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 Personal Physician/Provider.

These practitioners provide preventive care and health screening, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains and care for many major illnesses and nearly all minor illnesses and conditions. Many may offer maternity care and minor outpatient surgery as well.

IMPORTANT NOTE: Participating PCP/PPP/Providers have a special agreement with Providence Health Plan to serve as a case manager for your care. This means not all of our Participating Providers with the specialties listed above are Participating PCPs/PPPs/Providers. Please refer to the Provider Directory, available online, for a listing or call PHP Customer Service to request a hard copy. For the purposes of the Providence Health & Services plans, you are not required to select a PCP/PPP; however, to receive the reimbursement rates only available for PCP/PPP care you will need to receive care from one of the five areas of practices listed above.

Prior authorization

Prior authorization or prior authorized means a request to Providence Health Plan (PHP) or its authorizing agent by you or by a qualified practitioner regarding a proposed service, for which prior approval is required.

Prior authorization review will determine if the proposed service is eligible as a covered. To facilitate review of the prior authorization request, PHP may require additional information about the covered person's condition and/or the services requested. They may also require that a covered person receives further evaluation from a qualified practitioner of their choosing. Services that require prior authorization are shown in the **Prior Authorization/Medical Review** section.

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.
- A determination that relates to eligibility is obtained no more than five business days prior to the date of the service.

Provider

See health care provider.

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 as defined by applicable state law.

Residential mental health or chemical dependency facility
A residential facility is a program or facility approved by the State Mental Health Division or accredited by the Joint Commission on Accreditation of Healthcare Organizations that provides an organized full-day or part-day program of treatment for alcoholism, drug addiction or mental illness, but is not licensed to admit patients who require 24-hour skilled nursing care.

Second surgical opinion
Examination by a physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery to evaluate the medical advisability of undergoing a surgical procedure.

Self-funded
A term used to describe an arrangement in which the plan does not use insurance to pay health or other welfare benefits.

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 covered person by a qualified practitioner.

Skilled nursing facility
A public or private facility, licensed and operated according to the law, which maintains permanent and full-time facilities for 10 or more resident patients; has a nurse or physician on full-time duty in charge of patient care; has at least one registered nurse or licensed practical nurse on duty at all times; maintains a daily medical record for each patient; and has transfer arrangements with a hospital and a medical review plan in effect.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care for the aged or disabled.

Specialty Drug
Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.

Surgery
Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision.

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 or 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 PHP, the claims administrator. 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 checkups, follow-up care and prescription drug requests.

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.

Dental

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this***.

Your Dental Plan Options

Providence offers the following dental plan options:

- Delta Dental PPO 2000 Plan (with Orthodontia for adults and children)
- Delta Dental PPO 1500 Plan (no Orthodontia)
- DeltaCare USA DHMO Plan (where offered) See Appendix
- No coverage (Waive)

You may elect to waive coverage, or you may elect coverage for yourself, your spouse, Adult Benefits Recipient (ABR) and/or eligible dependent children. The cost of your dental coverage depends on who you enroll.

You do not need to enroll in medical coverage to elect dental coverage, and your coverage level for dental benefits does not have to be the same as your coverage level for medical benefits.

Dental coverage is administered by Delta Dental of Washington ("DDWA"), part of the Delta Dental Plans Association ("Delta Dental").

Choosing Dental Coverage

How do you decide which option is best for you? You may want to consider the following:

- What dental expenses do you expect in the coming plan year?
- What is the cost of purchasing the dental coverage compared to what the plan covers?
- Do you have any other sources of dental coverage?
- Will you need orthodontia coverage?

No Dual Coverage

The Plan does not allow dual coverage for Providence employees. Please review the **No Dual Coverage** section in the **Eligibility and Enrollment** chapter for more information.

How to Obtain Dental Services

With the PPO plans, you may select any licensed ***dentist***; however, your out-of-pocket expenses are lower if you choose a ***Delta Dental participating dentist***. Seeking care from a ***Delta Dental PPO dentist*** will ensure you receive the largest discounts and lowest out-of-pocket cost.

There are advantages to receiving care from a Delta Dental member dentist. Participating dentists:

- Have agreed to provide treatment according to the provisions of a member dentist contract.
- Will not charge more than the contracted discount rate.
- Will submit claim forms to DDWA on your behalf.

When you seek care, tell your dentist that you are covered by a Delta Dental plan and provide your identification number. The Plan will pay your dentist directly.

You can find a participating ***dentist*** in your area by visiting the Delta Dental website at www.deltadentalwa.com. Under **Find a Dentist**, enter your location, then from the drop-down menu under **Select Network**, choose **Delta Dental PPO**. You can also reach Delta Dental by calling 800-554-1907.

Delta Dental PPO Dentists

Delta Dental PPO dentists have agreed to provide services at a cost lower than their original fees in order to participate in the PPO network. No matter which dental plan you choose, you can choose any dentist – in or out of the PPO network. However, if you select a dentist who is part of the Delta Dental PPO network, your out-of-pocket expenses will be lower.

PPO dentists receive payment based on their pre-approved PPO fees and cannot charge you more than those fees. You will be responsible for your stated ***deductible***, coinsurance and/or amounts in excess of the plan maximums.

Delta Dental Premier® Dentists

Delta Dental Premier® dentists are also ***participating dentists*** and have agreed to provide services at a pre-approved fee. ***Premier® dentists*** do not participate in the PPO network and therefore the pre-approved fees charged are higher than those of a PPO dentist; however, they cannot charge you more than their pre-approved fees. You will be responsible for your stated ***deductible***, coinsurance and/or amounts in excess of the plan maximums.

If you select a Delta Dental Participating Dentist, they will complete and submit claim forms and receive payment directly from Delta Dental on your behalf. Payment will be based on the pre-approved fees your dentist has filed with their local Delta Dental plan. You will not be charged more than the Participating Dentist's approved fee. You will be responsible only for stated coinsurances, ***deductibles***, any amount over the plan maximum and for any elective care you choose to receive outside the covered dental benefits.

Nonparticipating Dentists

For a ***dentist*** who is not a member of the Delta Dental network, you:

- Are responsible for having the dentist complete and sign claim forms. You will need to submit the claim.
- May need to pay your dentist and then submit a claim to DDWA for reimbursement.
- May pay more than you would for care at a Delta Dental dentist. The Plan will reimburse claims based on actual charges or the Delta Dental's ***maximum allowable fees*** for nonparticipating dentists, whichever is less. You will be responsible for any balance owed above the allowable amount that the Plan will pay.

Delta Dental has no control over nonparticipating dentists' charges or billing practices.

DeltaCare USA DHMO Dentists

The DeltaCare USA DHMO plan uses a smaller, specialized network and you must use an in-network dentist for services to be covered. You can find a participating DHMO dentist in your area by visiting the

Delta Dental website at **DeltaDentalins.com**. Under **Find a Dentist**, enter your location, then from the drop-down menu under **Select Network**, choose **DeltaCare USA**.

Summary of Dental Coverage

The Plan pays for dental services as shown in the table below. These payments are subject to the annual calendar year plan maximum, which is the most the Plan will pay in a calendar year for all covered services, including preventive services. **For DHMO plan details, refer to the Appendix**.

Dental Plan Feature	Delta Dental 1500 Plan		Delta Dental PPO 2000 Plan	
	In Network (PPO)	Out-of-Network (Premier & Nonparticipating)	In Network (PPO)	Out-of-Network (Premier & Nonparticipating)
Annual calendar year deductible	$50 per person $150 maximum per family		$50 per person $150 maximum per family	
Annual calendar year maximum	$1,500 per person		$2,000 per person	
Class I - Diagnostic and Preventive Exams, prophy's, X-rays, fluoride and sealants	100% of allowed amount, no deductible	80% of allowed amount, no deductible*	100% of allowed amount, no deductible	80% of allowed amount, no deductible
Class II - Restorative Restorations, ***endodontics***, ***periodontics***, oral surgery	80% of allowed amount, after deductible	70% of allowed amount, after deductible*	80% of allowed amount, after deductible	70% of allowed amount, after deductible
Class III - Major Crowns, dentures, partials, bridges and implants	50% of allowed amount, after deductible		50% of allowed amount, after deductible	
Orthodontia Braces and dental appliances	Not covered		50% of allowed amount, up to a $2,000 lifetime maximum, after $50 lifetime deductible	

*Alaska/Montana Caregivers: Diagnostic and Preventative Out-of-Network is 100% of allowed amount, after deductible; and Restorative Out-of-Network is 80% of allowed amount, after deductible.

Note: Please review the Coordination of Benefits section of the General Medical, Dental, and Vision Information chapter for information about how this Plan's coverage works with other dental coverage you may have.

Save on Dental Expenses

You can save taxes on your out of pocket covered dental expenses if you choose to use the Health Care FSA. For more information, please review the **Health Care Flexible Spending Account** chapter.

Dental Benefits

Delta Dental PPO 1500 and Delta Dental PPO 2000 Plans

Class I - Diagnostic & Preventive Benefits

The Plan will pay 100% in network and 80% out of network of the ***maximum allowable fee*** or the actual charge, whichever is less, with no ***deductible*** for expenses considered preventive according to all provisions, requirements and limitations of the Plan.

Diagnostic Services

Covered dental benefits:

- Comprehensive, or detailed and extensive oral evaluation
- Diagnostic evaluation for routine or emergency purposes
- X-rays
- Study models

Detail of covered benefits, with limitations:

- Comprehensive, or detailed and extensive oral evaluation is covered once in a patient's lifetime by the same ***dentist***. Subsequent comprehensive or detailed and extensive oral evaluations from the same dentist are paid as a ***periodic oral evaluation***.
- Routine evaluation is covered twice in a calendar year from the date of service. Routine evaluation includes all evaluations except limited problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a calendar year.
- ***Bitewing X-rays*** are covered twice in a calendar year from the date of service.
- A complete series or ***panoramic X-ray*** is covered once in a three-year period from the date of service.
    - Any number or combination of X-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.

Exclusions:

- Consultations – diagnostic service provided by a ***dentist*** other than the requesting dentist
- Diagnostic services and X-rays related to ***temporomandibular joints*** (jaw joints) are not a Class I ***covered dental benefit***.

Preventive Services

Covered dental benefits:

- ***Prophylaxis*** (cleaning)
- Periodontal maintenance

- Topical application of fluoride including fluoridated varnishes
- ***Sealants***
- Space maintainers
- Preventive resin restoration and fissure sealants

Detail of covered benefits, with limitations:

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period from the date of service.
- Periodontal maintenance procedures are covered only if the patient has completed active periodontal treatment.
- For any combination of adult prophylaxis and periodontal maintenance, third and fourth occurrences may be covered if the ***dentist*** determines the patient meets periodontal Case Type III or IV (pocket depth readings of 5mm or greater).
- Topical application of ***fluoride*** is limited to two covered procedures in a benefit period from the date of the service.
- The application of a sealant is a covered dental benefit once in a three-year period per tooth from the date of service.
- Available for children through age 15.
- Benefit coverage for application of ***sealants*** is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
- If eruption of permanent molars is delayed, sealants will be allowed if applied within 12-months of eruption with documentation from the attending dentist.
- Space maintainers are covered once in a patient's lifetime through age 13 for the same missing tooth or teeth.
- The application of a preventive resin restoration is a covered dental benefit once in a three-year period per tooth from the date of service for either fissure sealant or preventive resin restoration (but not both)
- Available for children through age 15.
- If eruption of permanent molars is delayed, preventive resin restorations will be allowed if applied within 12 months of eruption with documentation from the attending ***dentist***.
- Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
- The application of a preventive resin restoration is not a covered dental benefit for three years after a sealant or preventive resin restoration on the same tooth.

Exclusions:

- Plaque control program (oral hygiene instruction, dietary instruction and home ***fluoride*** kits)

Class II – Restorative Benefits

The Plan will pay 80% in-network and 70% out-of-network (80% out-of-network for Alaska/Montana) or the lesser of the ***maximum allowable fee*** or the actual charges, whichever is less, after the annual ***deductible*** is met, for expenses considered restorative services according to all provisions, requirements, and ***limitations*** of the Plan.

Restorative

Covered dental benefits:

- Restorations (fillings)
- Stainless steel crowns

Please refer to the Major Expenses (Class III) benefit for coverage of ***crowns***, ***veneers*** or ***onlays***.

Details of covered benefits, with limitations:

- Restorations (fillings) to treat carious lesions (visible destruction resulting from dental decay) or to treat a fracture resulting in significant damage to tooth structure (missing cusp) or existing restoration on the same surface(s) of the same tooth are covered.
- If a ***resin-based composite*** or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it will be considered an elective procedure and an ***amalgam*** allowance will be made, with any difference in cost being the responsibility of the patient.
- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- Stainless steel crowns are covered once in a two-year period from the ***seat date***.

Exclusions:

- Overhang removal
- ***Copings***
- Re-contouring or polishing of a restoration
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion

Oral Surgery

Covered dental benefits:

- Removal of teeth
- Preparation of the mouth for the insertion of ***dentures***
- Treatment of pathological conditions and traumatic injuries of the mouth

Exclusions:

- Bone replacement graft for ridge preservation
- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth
- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling
- Orthognathic surgery or treatment

Sedation

Covered dental benefits:

- ***General anesthesia***
- ***Intravenous sedation***

Detail of covered benefits, with limitations:

- Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day when administered by a licensed ***dentist*** or licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington or as determined by the state in which the services are provided .
- General anesthesia is covered in conjunction with certain covered oral surgery procedures, as determined by Delta Dental of Washington or when medically necessary, for children through age 6 or a physically or developmentally disabled person, when in conjunction with Diagnostic &

Preventive, ***Restorative***, Major, and ***Orthodontic*** covered dental procedures. Predeterminations are recommended.
- Intravenous sedation is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA.
- Sedation, which is either General Anesthesia or Intravenous Sedation, is a Covered Dental Benefit only once per day.

Exclusions:
- General Anesthesia or Intravenous Sedation for routine post-operative procedures is not a paid Covered Dental Benefit except as described above for children through the age of six or a physically or developmentally disabled person.

Palliative Treatment

Covered dental benefits:

- ***Palliative treatment*** for pain

Detail of covered benefits, with limitations:
- Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Periodontics

Some benefits are available only under certain conditions of oral health. It is recommended that you have your ***dentist*** submit a predetermination of benefits to ensure the treatment will be covered. A predetermination is a guarantee of payment for up to 90 days after it is issued.

Covered dental benefits:

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Periodontal scaling/root planing
- Periodontal surgery
- Limited adjustments to occlusion (eight teeth or fewer)
- Gingivectomy

Please refer to the Preventive benefit for periodontal maintenance benefits.

Detail of covered benefits, with limitations:

- Periodontal scaling/***root planing*** is covered once in a two-year period from the date of service
- Gingivectomy or gingivoplasty is covered once in a three-year period from date of service
- Limited occlusal adjustments are covered once in a 12-month period from date of service
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
    - Periodontal surgery must be preceded by scaling and root planning within a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- Soft tissue grafts (per site) are covered twice per quadrant in a three-year period from the date of service.

Endodontics

Covered dental benefits:

- Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy and ***apicoectomy***

Detail of covered benefits, with limitations:

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a dentist other than the dentist who performed the original treatment and only if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

Exclusions:

- Bleaching of teeth

Class III – Major Benefits

After the annual ***deductible*** has been met, the Plan will pay 50% of the ***maximum allowable fee*** or the actual charges, whichever is less, for expenses considered major services according to all provisions, requirements, and ***limitations*** of the Plan.

Periodontics

Covered dental benefits:

- Occlusal guard (nightguard)
- Repair and relines of occlusal guard
- Complete occlusal equilibration

Detail of covered benefits, with limitations:

- Occlusal guard is covered once in a three-year period from the date of service
- Repair and relines done more than six months after the date of initial placement are covered
- Complete occlusal equilibration is covered once in a lifetime

Restorative

Covered dental benefits:

- ***Crowns***, ***veneers*** and ***onlays*** for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- Crown buildups
- Post and core on endodontically treated teeth
- ***Implant*** supported crown

Detail of covered benefits, with limitations:

- Crowns, veneers or onlays on the same teeth are covered only once in a five-year period from the original ***seat date***.
- An implant-supported crown on the same tooth is covered once in a five-year period from the original seat date of a previous crown on the same tooth.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an ***amalgam*** allowance will be made, with any difference in cost being the responsibility of the enrolled person, once in a two-year period from the seat date.
- Payment for a crown, veneer, inlay or onlay shall be paid based upon the date that the treatment or procedure is completed
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than two mm of vertical height remaining for 180

degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- A crown buildup is a covered once in a two-year period on the same tooth from the date of service
- A post and core are covered once in a five-year period on the same tooth from the date of service.
- Crown buildups or a post and core is not a paid covered dental benefit within two years of a restoration on the same tooth from the date of service.
- A crown used for purposes of recontouring or repositioning a tooth to provide additional retention for a removable partial ***denture*** is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- Ceramic substrate/porcelain or cast metal crowns and onlays are not a paid covered dental benefit for children under 12 years of age.

Exclusions:

- ***Copings***
- A ***crown*** or ***onlay*** is not a covered dental benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations

Prosthodontics

Covered dental benefits:

- ***Dentures***
- ***Fixed partial dentures*** (fixed ***bridges***)
- ***Inlays*** when used as a retainer for a fixed partial denture (fixed ***bridge***)
- Removable partial dentures
- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of ***implants*** or attachments to implants

Detail of covered benefits, with limitations:

- Replacement of an existing prosthetic appliance is covered only once every five years and only then if it is unserviceable and cannot be made serviceable
- Fixed ***prosthodontics*** for children less than 16 years of age are not a paid covered dental benefit.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge), and removable partial dentures shall be paid upon the seat/***delivery date***
- Implants and superstructures are covered once every five years.
- Full and immediate ***dentures*** – the Plan will allow the cost of full or immediate denture toward the cost of an elective procedure such as an ***overdenture***, a personalized restoration, or a specialized treatment.
- Temporary dentures – the Plan will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- Stayplate dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth

- Denture adjustments and relines – adjustments and ***relines*** done more than six months after the initial placement are covered two times in a 12-month period. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions:

- ***Crowns*** in conjunction with overdentures
- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic appliance
- ***Copings***
- Root canal treatment performed in conjunction with overdentures

Orthodontic Treatment – offered only to Delta Dental PPO 2000 Plan Participants

After payment of the $50 lifetime orthodontic ***deductible***, the Plan will pay 50% of the maximum allowable fee or the actual charges, whichever is less, up to the lifetime orthodontic maximum of $2,000 for expenses related to ***orthodontic*** services according to all provisions, requirements, and ***limitations*** of the Plan.

Orthodontia benefits are paid according to a schedule, not as a single sum. Not more than $1,000 of the maximum, or one-half of DDWA's total responsibility, shall be payable at the time of initial banding. Subsequent payments of the plan benefits will be made quarterly following the initial banding as long as you, and your dependent if the dependent is the patient, are continuously covered under this option.

It is strongly suggested that an orthodontic treatment plan be submitted , and a confirmation of treatment and cost be made by, Delta Dental of Washington before beginning treatment. A predetermination is not a guarantee of payment. Please refer to the **Confirmation of Treatment and Cost** section for more information.

A confirmation of treatment and cost is not a guarantee of payment. Please refer to the Confirmation of Treatment and Cost section for more information.

Additionally, payment for orthodontic benefits is based upon eligibility. If an individual is no longer enrolled on the dental Plan prior to the payment of all scheduled benefits, subsequent benefit payments will not be made.

Covered dental benefits:

- Fixed or removable appliance therapy for the treatment of teeth or jaws
- Orthodontic records: exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films

Detail of covered benefits, with limitations:

- Payment is limited to:
  - Completion of the treatment plan, or through when the patient is no longer covered under the Plan, whichever occurs first
  - Treatment received after coverage begins (claims must be submitted to DDWA within 180 days of the treatment date); for orthodontia claims, the initial banding date is the treatment date
- Treatment that began prior to the start of coverage will be prorated.

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  - The allowable payment will be calculated based on the balance of treatment costs remaining on the date of eligibility.

- Delta Dental will issue payments based on the Plan's responsibility for the length of the treatment. The payments are issued providing the employee is eligible and the dependent is in compliance with the age ***limitation***.

Exclusions:

- Charges for replacement or repair of an appliance
- No benefits shall be provided for services considered inappropriate and unnecessary, as determined by DDWA.

Accidental Injury Benefits

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II, and Class III covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused plan maximum. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage is available during the benefit period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

Confirmation of Treatment and Cost (formerly called Predeterminations)

If you or your dependent is considering a ***course of treatment*** which will result in dental expenses in excess of $250, or anytime out-of-pocket expenses is a concern, it is a good idea to submit a request to Delta Dental of Washington (DDWA) to determine what portion of the cost will be covered by the Plan.

A Confirmation of Treatment and Cost is a request made by your ***dentist*** to DDWA to determine your benefits for a particular service. A nonparticipating dentist can also do so using any American Dental Association-approved form; you may also obtain a dental claim form from the Delta Dental website.

DDWA will notify you and your dentist of the estimated benefit payments you may receive based on what was submitted for approval. This Confirmation of Treatment and Cost will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A Confirmation of Treatment and Cost is not an authorization for services but a notification of Covered Dental Benefits available at the time of the Confirmation of Treatment and Cost is made and is not a guarantee of payment.

A standard Confirmation of Treatment and Cost is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete, DDWA will notify you and your dentist in writing that additional information is required in order to process the Confirmation of Treatment and Cost. Once the additional information is available, your dentist should submit a new request for Confirmation of Treatment and Cost to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this plan, the Confirmation of Treatment and Cost is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

Urgent Confirmation of Treatment and Cost Requests

Should a Confirmation of Treatment and Cost request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or ***dentist*** who has knowledge of the medical condition, DDWA will review the request within 72 hours from the receipt of the request and all supporting

documentation. When practical, DDWA may provide notice of the determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is not allowed without a requirement to obtain a Confirmation of Treatment and Cost in an emergency situation subject to the contract provisions.

Continuation of Coverage (COBRA)

You and your covered dependents may be entitled to continue coverage under this plan, at your expense, if certain conditions are met. Please refer to the **Optional Continuation of Coverage (COBRA)** chapter for additional information.

General Exclusions

The benefits covered under this plan are subject to limitations and exclusions listed in the benefits sections above which affect the type or frequency of procedures which will be covered. Additionally, this Plan does not cover every aspect of dental care. There are exclusions to the type of services that are covered, which are detailed in this section. All limitations and exclusions warrant careful reading. These items are not paid ***covered dental benefits*** under this plan.

1. Dentistry for cosmetic reasons.
2. Restoration or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
3. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4. Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5. Experimental services or supplies;
    a. This includes:
        i. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
            - The services are in general use in the dental community in the state of Washington;
            - The services are under continued scientific testing and research;
            - The services show a demonstrable benefit for a particular dental condition; and
            - They are proven to be safe and effective.
    b. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
    c. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such an appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.
    d. Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating licensed professional determines that

delay could jeopardize the covered person's health or ability to regain maximum function DDWA shall presume the need for expeditious determination in any independent review.

6. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
7. Prescription drugs.
8. Hospitalization charges and any additional fees charged by the ***dentist*** for hospital treatment.
9. Charges for missed appointments.
10. Behavior management.
11. Completing claim forms.
12. Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance, etc.), this does not include ***occlusal guard***.
13. TMJ services or supplies.
14. This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
15. All other services not specifically included in this plan as ***covered dental benefits***.

Glossary

You may also see definitions for these terms on your Explanation of Benefits or in other benefits materials.

Amalgam
A mostly silver filling often used to restore decayed teeth.

Apicoectomy
Surgery on the root of the tooth.

Bitewing X-ray
An X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gum line, as well as a portion of the roots and supporting structures of these teeth.

Bridge
Also known as a fixed partial denture.

Coping
A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. The purpose of a coping is to allow the removal and modification of the bridge without requiring a major remake of the bridgework, if the tooth is lost.

Covered dental benefits
Those dental services that are covered under this contract, subject to the limitations set forth in benefits covered by your plan.

Crown
A restoration that replaces the entire surface of the visible portion of tooth.

Delivery date
The date a prosthetic appliance is permanently cemented into place.

Deductible
The amount you must pay for dental care each year before Delta Dental benefits begin.

Delta Dental PPO Dentist
A participating dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental PPO agreement, which includes looking solely to Delta Dental for payment of covered services.

Delta Dental Participating Dentist (Premier)
A licensed dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written agreement between Delta Dental and such dentist, which includes looking solely to Delta Dental for payment for covered services.

Dentist
A licensed dentist legally authorized to practice dentistry at the time and in the place services are performed. This plan provides for covered services only if those services are performed by or under direction of a licensed dentist or other licensed professional operating within the scope of their license.

Denture
A removable prosthesis that replaces missing teeth. A complete (or “full”) denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper and lower teeth.

Endodontics
The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Fixed partial denture
A replacement for a missing tooth or teeth. The fixed partial denture consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). They are cemented (fixed) in place and therefore are not removable.

Fluoride
A chemical agent used to strengthen teeth to prevent cavities.

General anesthesia
A drug or gas that produces unconsciousness and insensibility to pain.

Implant
A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay
A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intravenous (I.V.) sedation
A form of sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

Lifetime maximum
The maximum amount DDWA will pay in the specified covered dental benefit class for an insured individual during the time that individual is on this plan or any other plan offered by the employer.

Limitation
An exception or condition of coverage for a particular covered dental benefit.

Nonparticipating Dentist
A licensed dentist who has not agreed to render services and receive payment in accordance with the terms and conditions of a written member dentist agreement between a member of the Delta Dental Plans Association and such dentist.

Occlusal adjustment
Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal guard
A removable dental appliance – sometimes called a nightguard – that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard (nightguard) is typically used at night.

Onlay
A restoration of the contact surface of the tooth that covers the entire surface.

Orthodontics
Diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture
A removable denture constructed over existing natural teeth or implanted studs.

Palliative treatment
Services provided for emergency relief of dental pain.

Panoramic X-ray
An X-ray, taken from outside the mouth that shows the upper and lower teeth and the associated structures in a single picture.

Payment Level
The applicable percentage of Maximum Allowable Fees for Covered Dental Benefits that shall be paid by DDWA as set forth in the Summary of Benefits and Reimbursement Levels sections of this Benefits Booklet.

Periodic oral evaluation – (routine examination)
An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics
The diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

Prophylaxis
Cleaning and polishing of teeth.

Prosthodontics
The replacement of missing teeth by artificial means such as bridges and dentures.

Pulpotomy
The removal of nerve tissue from the crown portion of a tooth.

Resin-based composite
A tooth colored filling, made of a combination of materials, used to restore teeth.

Restorative
Replacing portions of lost or diseased tooth structure with a filling or crown to restore proper dental function.

Root planing
A procedure done to smooth roughened root surfaces.

Sealants
A material applied to teeth to seal surface irregularities and prevent tooth decay.

Seat date
The date a crown, veneer, inlay or onlay is permanently cemented into place on the tooth.

Temporomandibular joint
The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Veneer(s)
A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation or mechanical retention.

Vision

Overview

Providence offers vision coverage through Vision Service Plan (VSP). You may elect to waive coverage, or you may elect coverage for yourself, your spouse, Adult Benefits Recipient (ABR) or and/or eligible dependent children. The cost of your vision coverage depends on who you enroll.

You do not need to enroll in medical coverage to elect vision coverage, and your coverage level for vision benefits does not have to be the same as your coverage level for medical benefits.

No Dual Coverage

The Plan does not allow dual coverage for Providence employees. Please review the **No Dual Coverage** section in the **Eligibility and Enrollment** chapter for more information.

How to Obtain Vision Services

Vision Service Plan (VSP) covers eye exams, prescription eyeglasses, and/or prescription contact lenses. You can go to any provider you wish, but you'll receive a higher level of benefits if you choose a doctor who participates in the VSP network.

VSP and Affiliate Providers

When you use a VSP provider, most services are covered in full after the copay and there are no claim forms to file. You will also receive discounts and preferred member pricing for glasses and contacts. You may select any VSP provider, however your out-of-pocket expenses are lower if you choose a provider in the VSP Choice Network. To determine if your provider is part of VSP's network, or to find a new vision care provider, contact VSP Customer Service at 800-877-7195 or visit VSP's website at **vsp.com** and log in.

Affiliate providers do not belong to the VSP network, but they have agreed to bill VSP directly for covered services and to receive payment at the levels of VSP member providers. **Some affiliate providers may not be able to provide all the services included in this Plan.**

At the time of your appointment, identify yourself as a VSP member. You will pay the copay (if any) to your provider for covered services, plus any charges in excess of the Plan benefits. The provider will handle the paperwork to receive payment from VSP.

Non-Member Providers

If you seek vision care from a non-member provider, you will be responsible for paying the full cost of care and then submitting a claim for reimbursement to VSP. You must submit your claim within one year of the date of service. Please visit **vsp.com** and once you are logged in you can obtain a claim form and instructions on how to submit your claim.

Summary of Vision Coverage

The Plan pays for vision services as shown in the table below. Benefits are only available once every 12 months or every 24 months, depending on the service.

Activity	VSP Member Provider	Affiliate Provider	Non-Member Provider
Eye Exam	100% after $15 copay, once every 12 months	$100% after $15 copay once every 12 months	Up to $50 allowance once every 12 months after $15 copay
Prescription Glasses The Plan covers glasses **or** contact lenses (described below).			
• Lenses — Single vision, lined bifocal, lined trifocal lenses, lenticular lenses, — Progressive, photochromic, tints and dyes, ultraviolet coating, scratch coating and antireflective coating — Polycarbonate lenses are covered for dependent children up to age 18	100% once every 12 months	100% once every 12 months	Once every 12 months • Up to $40 allowance for single vision, or • Up to $60 allowance for lined bifocal, or • Up to $80 allowance for lined trifocal, or • Up to $125 allowance for lenticular and • Up to $5 for tinting (total)
• Frame of your choice	• 100% once every 24 months, up to $120 allowance or, up to $140 allowance for featured frame brands • 20% savings on the amount over the allowance	• 100% once every 24 months, up to $120 allowance • 20% savings on the amount over the allowance. • Up to $65 allowance at Costco	• Up to $45 allowance once every 24 months
• Additional discounts and savings	• Non-covered lens enhancements are cost controlled with an average of a 30% savings • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam • Retinal screening – no more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	• Costco — Costco pricing applies; there are no additional discounts • All other Affiliate Provider locations — 20% off additional glasses and 15% off contact lens services within one year	Not available

Activity	VSP Member Provider	Affiliate Provider	Non-Member Provider
OR			
Contact Lens Care The Plan covers glasses (described above) or contact lenses.			
• Includes cost of your: — Contacts — Contact lens fitting and evaluation exam (in addition to vision exam)	• 100%, once every 12 months up to $200 allowance for elective contact lenses OR • Visually necessary contact lenses at 100%, once every 12 months; eligibility for these types of contact lenses are determined by prescribing doctor	• 100% once every 12 months up to $200 allowance for elective contact lenses	• Up to $200 allowance once every 12 months for elective contact lenses OR up to $210 allowance for visually necessary contact lenses (claim will be reviewed to determine if member meets approved benefit criteria), once every 12 months
• Additional discounts and savings	• 15% off cost of contact lens exam (fitting and evaluation).	• Costco — Costco pricing applies; there are no additional discounts • All other Affiliate Provider locations — 15% off contact lens services within one year	Not available
Laser Vision Correction			
	• Average 15% off the regular price or 5% off the promotional price: discounts are available from contracted facilities	Not available	Not available

The benefit frequency limits will apply even if there is a break in coverage and you re-enroll for VSP coverage.

Note: Please review the Coordination of Benefits section of the General Medical, Dental and Vision Information chapter for information about how this Plan's coverage works with other medical or vision coverage you may have.

Save on Vision Expenses

You can save on taxes on your out of pocket covered vision expenses if you choose to use the Health Care FSA. For more information, please review the **Health Care Flexible Spending Account** chapter.

Additional Benefits

If you or a covered family member has severe visual problems that cannot be corrected with regular lenses, you may be eligible for additional benefits. The VSP provider will determine if you meet the criteria for low-vision benefits at the time of service. The VSP provider will submit a verification form and obtain a Benefit Authorization Notice from VSP before proceeding with these additional services.

Complete low-vision analysis/diagnosis includes a comprehensive exam and subsequent low-vision aids as visually necessary or appropriate. Low-vision aids are services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

What Is Covered	VSP Provider	Non-Member Provider
Supplemental Testing	100%	Up to $125
Supplemental Care Aids	75%	75%*
Benefit Maximum	$1,000 every two years Maximum of two supplemental tests in a two-year period	
*Low vision isn't supported at Costco/Affiliate locations. Coverage is available through non-network providers; however, a greater out-of-pocket cost may occur based upon out-of-network limitations for coverage of specific services and aids.		

Non-Member Provider Benefit

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

Exclusions and Limitations

The VSP plan is designed to cover visual needs rather than cosmetic materials. If you choose any of the following extra features, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for payment of the additional cost. Discounts may be available with VSP providers.

- Optional cosmetic processes
- Color coating
- Mirror coating
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Certain limitations on low-vision care
- Frames that cost more than the plan allowance
- Contact lenses (except as noted)

No benefits will be payable for the following:

- Care, treatment or supplies received prior to or after coverage under this Plan
- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than ±.50 diopter power)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision of an experimental nature
- Costs for services and/or materials above the Plan benefit
- Services and/or materials not indicated as covered in this chapter

General Medical, Dental and Vision Information

Claims for Medical, Dental PPO and Vision

For medical claims, always present your ID card to the provider and be sure the provider has the correct billing address for your benefits.

For the Dental PPO plan, ID cards are not required. Simply notify your provider that you are covered by Delta Dental and they will take care of the details. Your member identification number will be nine digits made up of leading zeros and your employee identification number. You can print an ID card from the Delta Dental website. Note: If you enroll in the DeltaCare USA DHMO Plan, you will receive an identification card in the mail when you initially enroll only along with an Evidence of Coverage (EOC) and Disclosure Form. The EOC provides detailed information on your benefits coverage, plan exclusions, limitations and claims procedures.

For the Vision plan, ID cards are not required. Simply notify your provider that you are covered by VSP and they will take care of the details. Your member identification number will be nine digits, made up of your social security number. You can print an ID card from the VSP website.

Copays, if any, will generally be collected by the provider at the time of service. If you use preferred or in-network providers or facilities, the provider will submit the claim on your behalf. The ***Claims Administrator*** will apply preferred/in-network provider discounts at the time the claim is processed.

If the provider requires you to pay your claim at the time of service, you will need to submit a claim for reimbursement unless you are using a preferred/in-network provider. Some out-of-network providers will submit the claim to the ***Claims Administrator*** for you. Claims for medical, dental or vision services are paid based on your coverage in effect at the time you incur the expense, not when you submit it. You incur an expense when you receive the treatment or service or when you purchase medical supplies covered by the Plans.

To ensure timely processing of claims, you are encouraged to submit your claim within 60 days of the date of services. The Plan will not pay claims received more than 12 months after the date of service, unless you can provide proof that you were legally incapacitated during that period.

When you submit a claim, you can expect it to be processed promptly, as long as it is timely submitted by and fully documented by your provider. Any claims not submitted within 12 months from the time services or supplies were received will not be paid by the Plans.

You will receive an Explanation of Benefits (EOB) from the Plan after your claim is processed. The EOB explains how the Plan processed your claim, and what share of the bill you must pay to the provider, if any. Copayment or coinsurance amounts, services, or amounts not covered and general information about the Plan's claim process are explained in the EOB.

Medical and Pharmacy Claims under the Medical Plans

Claim forms are available on the Providence Health Plan (PHP) website at **https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/** for services from out-of-network providers. You only need to submit a claim form if the out-of-network provider is unable or unwilling to bill PHP on your behalf. Be sure that you complete all sections of the

claim form except the provider section; then sign and date it. A separate claim form must be completed for each family member for whom a claim is filed.

Instead of having the provider complete the provider section of the claim form, you may attach an itemized bill. The itemized bill must include the following information:

- Identification number as shown on your medical ID card
- Patient name
- Type of service
- Description of the service (CPT or procedure code)
- Date of each service
- Diagnosis
- Charge for each service
- Provider's Tax Identification Number (TIN#)
- Provider's billing address
- National Provider Identifier (NPI)

Please make copies of all itemized bills and claim forms, they cannot be returned. Canceled checks and balance-due bills are not acceptable substitutes for itemized bills. Medical and pharmacy benefit claims should be submitted to Providence Health Plan:

Providence Health Plan
P.O. Box 3125
Portland, OR 97208-3125

Questions about Medical and Pharmacy Claims, Eligibility and Benefits

If you have questions about the status of your claim or if your provider would like to check your eligibility or benefits, call your Providence Health Plan Customer Service Team representative directly at 1-800-878-4445. The PHP customer service department is available to take your call Monday through Friday, from 8 a.m. through 5 p.m. Pacific Time, excluding holidays.

Health Reimbursement Account (HRA)

Unused funds remaining in your HRA at the end of the year will roll over to the next year as long as you remain enrolled in the HRA Medical Plan. Your account will remain active for 365 days from your medical plan coverage end date. During this time, you can submit claims for reimbursement for services that were received while covered under the HRA Medical Plan. After 365 days, these funds are no longer available to you. If you elect COBRA, you may also use the funds to be reimbursed for copayments, coinsurance and the deductible.

Pre-2016 Contributions + Five Years of Service: If your most recent hire date occurred before December 31, 2015 and you have five or more years of continuous employment, the HRA funds deposited into your account prior to December 31, 2015 ("Pre-2016 Funds") may be used (beyond the 365 day period described above) to be reimbursed for premiums paid for COBRA, a qualified long-term care plan or Medicare after leaving Providence.

If you have Pre-2016 Funds, any eligible claims you have reimbursed will first come from the Pre-2016 Funds until those funds are depleted, and then from your remaining account balance. The HRA funds are disbursed for reimbursement in the order in which the funds were deposited into your account.

For questions, you may contact HealthEquity at 877-372-6667.

Dental Claims

To find a dental claim form or information, visit **www.DeltaDentalWA.com.**

Dental claims for nonparticipating dentists should be sent to:

Delta Dental of WA
P.O. Box 75688
Seattle, WA 98175

For questions about dental claims, eligibility, and benefits, call your customer service team representative toll-free at 800-554-1907. Customer service representatives are available Monday – Friday 8 a.m. to 5 p.m., Pacific Time.

Note: if you have coverage under the DeltaCare DHMO plan, please refer to the Evidence of Coverage (EOC) and Disclosure Form for information on filing dental claims, if necessary. The EOC can be found in the Appendix of this document. The EOC governs the terms of coverage and describes the benefits, limitations, exclusions, claims and appeals procedures for that plan.

Vision Claims

To find a claim form or information, visit **www.vsp.com.**

Vision claims for non-member vision providers should be sent to:

Vision Service Plan (VSP)
P.O. Box 385018
Birmingham, AL 35238-5018

For vision care questions about claims, eligibility, and benefits, call your Member Services representative toll-free at 800-877-7195. Customer service representatives are available Monday – Friday 5 a.m. to 8 p.m., Pacific Time.

Plan definitions

At the end of this chapter you will find a **Glossary** that defines terms formatted ***like this.***

Claims Review and Appeal Process

The table below provides an overview of the medical claims review and appeal process. Definitions for each type of claim are provided in the **Glossary**. All time frames referenced are in calendar days unless stated in hours.

You must follow the specific procedures established by the Plan/insurance carrier. Please review the **Problem Resolution, ERISA & HIPAA Information** chapter for more information.

Note: The *Claims Administrator* will provide you with oral or written notification. If oral, a written or electronic notification will be provided to you no later than three days after the oral notification.

Type of Claim	When Claim Decisions Will Be Made	Your Deadline for Initial Appeal	When Appeal Decisions Will Be Made
Pre-Service Claims	• Within 15 days of receipt of your claim. • A one-time 15-day extension is allowed for matters beyond the control of the Plan. The Plan will notify member before the expiration of the initial 15-day time period • If your claim is incomplete, you will be notified within 15 days, and you will have at least 45 days to provide the necessary information. • The Plan will make a decision within 15 days of receipt of the requested information or within 15 days of the deadline for claimant to supply the requested information, whichever comes first.	For all types of claims, you have 180 days after receiving notice that your claim is denied to file an appeal, in writing, to the ***Claims Administrator***.	Medical appeal decisions will be made within 30 days of receipt of your request for review of a denied claim.
Urgent Care Medical Claims ***(Pre-Service)***	• Within 72 hours of receipt of your claim. • If your claim is incomplete, you will be notified within 24 hours after the ***Claims Administrator*** receives your claim, and you will have at least 48 hours to respond. In such case, a decision will be made within 48 hours of the earlier of the receipt of the information or the end of the period given to furnish the additional information. • The Plan will make a decision within 48 hours of receipt of the requested information or within 48 hours of the deadline for claimant to supply the requested information (whichever comes first)		Medical claims appeal decisions are made within 72 hours of receipt of your request for review of a denied claim.

Type of Claim	When Claim Decisions Will Be Made	Your Deadline for Initial Appeal	When Appeal Decisions Will Be Made
Post-Service Claims	• Within 30 days of receipt of your claim. • A one-time 15-day extension is allowed for matters beyond the control of the Plan. The Plan will notify member before the expiration of the initial 30-day time period. • If your claim is incomplete, you will have at least 45 days to provide the necessary information. • The Plan will make a decision within 15 days of receipt of the requested information or within 15 days of the deadline for claimant to supply the requested information, whichever comes first.		Medical claims appeal decisions will be made within 60 days of receipt of your request for review of a denied claim.
Concurrent Care Claims	• As soon as reasonably possible taking into account the medical exigencies and within 24 hours, provided the claim is made to the ***Claims Administrator*** within 24 hours before the expiration of the previously approved time or number of treatments. Requests made after this claims cutoff will be decided in the timeframes noted above. • Any reduction or termination of the course of treatment before the expiration of the previously approved period of time or number of treatments will constitute a claim denial. If this occurs, the ***Claims Administrator*** will notify the claimant of its decision at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a decision on appeal before the benefit is reduced or terminated.		Medical claims appeal decisions will be made within a reasonable amount of time appropriate to the medical circumstances but not later than 15 days after receipt of the request for review for each level of the claimant's appeal.

Note: If the *Claims Administrator* determines that special circumstances require an extension of time for processing the claim or appeal, you will be notified of that extension.

Coordination of Benefits (COB)

If you or your covered dependents have health benefit coverage through another employer, a government plan or Medicare, your Providence medical plan will coordinate payments to ensure the total paid by both plans will not exceed the total amount charged. This is called Coordination of Benefits (COB).

If you or your covered dependents receive payments for health care from other sources, such as motor vehicle or liability insurance, your Providence medical plan will seek to be reimbursed for benefits paid under the Plan or take over your right to receive payments from the other party. Review the **Benefits Paid by Other Sources** section for more information.

Your Providence benefits – medical, prescription drugs, dental, and vision, are subject to these provisions.

How COB Works

Medical

One group plan always pays first (the primary plan), and the other plan always pays second (the secondary plan). Your primary plan will pay for your services under its policy's terms first, and your secondary plan may pay any remaining out-of-pocket costs according to its terms.

This Plan features a non-duplication of benefits provision. If you are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of this Plan's negotiated fee will not be covered by this Plan.

Note: Each plan will pay only for services that are covered in their plans. When this Plan is the secondary plan, the total paid by this Plan and the primary plan combined will not exceed the maximum amount this Plan would have paid if it were primary.

Prescription Drugs

If you are covered by more than one plan for prescription drugs and the **Providence HRA Medical Plan** or **EPO Medical Plan** is the secondary plan, coordination of benefits will occur when your pharmacist enters the insurance information. If your pharmacy cannot bill your secondary insurance, you will be required to submit a Prescription Drug Reimbursement Request Form and your itemized pharmacy receipts for consideration of your claim. This form is available by calling the PHP Customer Service Team at 800-878-4445. PHP will coordinate payment with the primary plan in such a way that the total does not exceed 100% of the covered cost of the drug.

If the **Providence HSA Medical Plan** is the secondary plan, you will need to pay the balance left over after your primary plan has paid at the pharmacy. You will be required to submit a Prescription Drug Reimbursement Request Form and your itemized pharmacy receipts for consideration of your claim. This form is available by calling the PHP Customer Service Team at 800-878-4445. PHP will apply any balances left after your primary plan has paid toward the deductible. The plan will pay the remaining balance once your deductible has been met. PHP will coordinate payment with the primary plan in such a way that the total does not exceed 100% of the covered cost of the drug.

Dental

One group plan always pays first (the primary plan), and the other plan always pays second (the secondary plan). Your primary plan will pay for your services under its policy's terms first, and your secondary plan may pay any remaining out-of-pocket costs according to its terms.

When this plan is secondary, it will pay no more than the amount it would have paid if it were the primary plan, minus what the primary plan has paid. It will pay the amount which, when combined with what the primary plan paid, does not exceed 100 percent of the total allowable expense under this plan.

Vision

When this plan is secondary, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than, the billed amount. Only services received on the primary plan may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

When your Providence Plan Is Primary or Secondary

Providence will use the following rules to determine if the Providence plan is primary or secondary to other coverage.

Medicare

In most cases, the Providence medical plan is the primary plan if you or your dependents have coverage under Medicare, as long as you have coverage due to being actively working. Your Providence medical plan will coordinate benefits with Medicare as required by federal law. This plan complies with federal statutes and regulations to determine whether this plan or Medicare is primary.

Other Group Health Plans

For Providence employees, the Providence plan is generally the primary plan. If you are covered under the Providence plan and an ***affiliate's*** plan, the plan in which you were covered the longest is the primary plan.

For your spouse/Adult Benefits Recipient (ABR) who has other coverage, the following rules apply:

- If a group health plan does not contain a coordination of benefits provision, it will be the primary plan.
- When both plans contain a coordination of benefits provision:
  - The plan in which your spouse/ABR has employee (or subscriber) coverage will be the primary plan.
  - The plan in which your spouse/ABR has dependent coverage will be the secondary plan.

  If the rules above do not apply, the plan that has covered your spouse/ABR the longest is the primary plan.

Dependent Children

If a dependent child is covered under more than one plan, the following rules apply, unless there is a court decree stating otherwise:

- If the parents are married or live together (regardless of whether they have ever been married), the plan of the parent whose birthday comes first during the calendar year is primary (not taking into account the year in which they were born). If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. This is known as the "birthday rule." In cases where the other plan does not follow the birthday rule, the rule of the other plan applies.

- If parents are separated, divorced, or do not live together (regardless of whether they have ever been married), and a court order makes one parent responsible for paying the child's health care coverage/medical insurance, that parent's plan is the primary plan. If that parent does not have health care coverage for the dependent child's health care expenses, but that parent's spouse does, that spouse's plan is the primary plan. If there is a court order that allocates both parents are responsible for the child's health care expenses, or that specifies a joint custody arrangement, the birthday rule of the biological parents will determine the order of benefits.
- If there is no court order allocating responsibility for the Dependent child's health care expenses, 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.
- For a Dependent child who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the plan that has covered this person the longer period of time is the primary plan and the plan that has covered this person the shorter period of time is the secondary plan
  - 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 to the Dependent child's parent(s) and the Dependent's spouse.

COBRA

If a member whose coverage is provided pursuant to COBRA is covered under another plan, the plan covering the person as an employee or dependent of an employee is primary and the COBRA plan 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.

Right to Make Payments to Other Organizations

Whenever another plan pays benefits that should have been paid by this Plan, this Plan has the right to pay the other plan any amount necessary to satisfy the COB provision. Amounts paid will be considered benefits paid under this Plan and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

Benefits Paid by Other Sources

Situations may arise in which health care expenses are also covered by a source other than the Plan. If so, the Plan won't provide benefits that duplicate the other coverage. For example, the Plan won't provide benefits that duplicate those available to a covered person under no-fault motor vehicle or similar insurance.

If another plan is the primary plan, a copy of the other plan's explanation of benefits (EOB) should be included with the claim you submit to Providence Health Plan.

Recovery/Reimbursement

By enrolling in a health plan, you agree to the provisions of the recovery, reimbursement and coordination of benefits provisions, including ***subrogation***, as a condition of receiving benefits under the Plan. If you or your covered dependent fails to comply with the requirements, payment of benefits may be suspended.

Recovery

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, including coordination of benefits, the Plan has the right to recover the amount of the payments from any individual, insurance company, health care provider, or other organization to whom the excess payments were made. Whenever payments have been based on the insured's fraudulent act or intentional misrepresentation of material fact, the Plan has the right to withhold payment of benefits under the Plan until the overpayment is recovered.

Reimbursement

The Plan's right to reimbursement is separate from and in addition to the Plan's right of ***subrogation***. For more information on subrogation, please review the below.

Third-Party Liability

If someone else is legally responsible or agrees to compensate you for injuries suffered by you or a family member, you will need to reimburse the Plan for any benefits the Plan paid in connection with those injuries, whether or not you have been made whole by such compensation.

If the Plan requests that a ***subrogation*** statement or other repayment agreement be signed, the Plan's right to recovery through reimbursement and/or subrogation remains in effect, regardless of whether the statement or agreement is actually signed.

Failure to Refund Full Amount

If you or your dependent (and in the event of a dependent who is a minor, the dependent's representative) does not promptly ***refund*** the full amount that is due to the Plan under this provision, the Plan may reduce the amount of any future benefits that are payable to you or your dependent. The reductions will equal the amount the Plan paid in excess of the amount it should have paid. The Plan may have other rights in addition to the right to reduce future benefits or recover the amount due to the Plan.

Subrogation and Recovery

This provision applies when you or your dependent, referred to in this section as "covered person," may incur medical expenses due to injuries which may be caused by the act or omission of a ***third party*** or a third party may be responsible for payment.

In these circumstances, the covered person or the covered person's beneficiary may have a claim against that ***third party***, or insurer, for payment of the medical charges. Accepting benefits under the Providence Health & Services plan(s) for those incurred medical expenses automatically assigns to the Plan any rights the covered person may have to recover payments from any third party or insurer.

The Plan's share of the recovery shall not be reduced because you, your dependent, or your beneficiary has not received the full damages claimed, unless the Plan agrees in writing to a reduction.

Further, this ***subrogation*** right allows the Plan to pursue any claim the covered person has against any ***third party***, or insurer, whether or not the covered person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the covered person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

By accepting benefits under the Plan, the covered person must:

- Automatically assign to the Plan his or her rights against any ***third party*** or insurer when this provision applies and

- Repay to the Plan the benefits paid on his or her behalf out of the recovery made from the ***third party*** or insurer, or the Plan may recover from the covered person or his or her legal representative any benefits paid under the Plan from any payment the covered person receives, or is entitled to receive, from the third party

Amount Subject to Subrogation or Refund

The covered person agrees to recognize the Plan's right to ***subrogation*** and reimbursement. These rights provide the Plan with a 100%, first-dollar priority over any and all ***recoveries*** and funds paid by a ***third party*** to a covered person relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, or other costs and expenses. The Plan's priority amount is not to be reduced by attorney fees related to recovery, unless in the Plan Administrator's sole discretion it is determined that not sharing a portion of such fees or costs would be inequitable given the facts of a particular case. Accepting benefits under the Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the covered person may have to recover payments from any third party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the covered person's third-party claims.

The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical expenses from the covered person. Also, the Plan's right to ***subrogation*** still applies if the recovery received by the covered person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of recovery exists, the covered person will provide all required materials and do whatever is needed to secure the Plan's right of ***subrogation*** in return for having the Plan make payments. In addition, the covered person will do nothing to prejudice the right of the Plan to subrogate.

Before accepting any settlement on your claim against a ***third party***, you must notify PHP's Subrogation Department in writing of any terms or conditions offered in a settlement, and you must notify the third party of the Plan's interest in the settlement (established by this provision). You must also cooperate with the Plan in recovering amounts paid on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse the Plan directly from the settlement or recovery proceeds. Notify the PHP Subrogation Department at Third-Party Liability Team/Providence Health and Services Health Plan/P.O. Box 4327/Portland, OR 97208-4327.

Conditions Precedent to Coverage

The Plan shall have no obligation whatsoever to pay medical/dental benefits to a covered person if he or she refuses to cooperate with the Plan's reimbursement and ***subrogation*** rights, or refuses to deliver materials the Plan requires. In the event the covered person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of injury or sickness caused by a ***third party*** until after the covered person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar reimbursement and ***subrogation*** rights.

Right to Offset Future Benefits

After the covered person has received proceeds of a settlement or recovery from the ***third party***, the covered person 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, until all proceeds from the settlement or recovery have been exhausted. If the covered person 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 plan offered by Providence, to the extent of the value of the benefits advanced under this section.

If the covered person 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 covered person 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 the Plan 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 covered person for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by the Plan will be deemed first to compensate the covered person for 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.

Rights to Receive and Release Necessary Information

The Plan may, without your consent or notice, release to or obtain from any organization or person, information needed to implement Plan provisions. When you request benefits, you must furnish all the information required to implement Plan provisions.

Termination of Coverage

Coverage under the medical, dental and vision plans ends on the last day of the month in which:

- Your employment with Providence Health & Services ends or your hours are reduced to a non-benefits-eligible status
- You move to a non-covered position
- You die (coverage ends on date of death and at the end of the month for your covered dependents)
- A dependent or Adult Benefits Recipient ceases to be eligible due to marital or relationship status change or no longer meets plan criteria
- A dependent child turns age 26, unless disabled and approved for continued coverage by Claims Administrator
- Required contributions are not made
- The group policy is discontinued

Termination of Coverage Due to Fraud or Abuse

Your Plan coverage may be rescinded retroactively (up to being deemed from the beginning as never effective) if you perform an act, practice or omission that constitutes fraud on an enrollment or in a claim for benefits, or if you make an intentional misrepresentation of material fact to the Plan Administrator regarding any information material to your eligibility for benefits.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and reserves the right to recover from you or your covered dependent the benefits paid a as a result of such wrongful activity. In addition, the Plan may deny future enrollment to you and to your dependent under any Providence medical plan for a period of five years from such rescission or termination. The Plan Administrator will provide you with written notice at least 30 days in advance of the rescission of your coverage. Any rescission of coverage is treated as an adverse benefit determination.

A retroactive termination due to your failure to pay is not considered a rescission. In this situation, COBRA continuation coverage is not available.

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials.

Affiliate

Another health care entity affiliated with Providence St. Joseph Health, and whose benefits are administered through Providence St. Joseph Health.

Claims administrator

A third party administrator or insurer designated by the plan administrator or its delegate to review and process claims for benefits under the Plan.

Concurrent care claim

A request that involves both Urgent Care Medical Claims and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the Plan.

Post-service claim

Any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.

Pre-service claim

Any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.

Recoveries

Money paid to the covered person through a judgment, settlement, or otherwise to compensate for all losses caused by an injury or sickness, whether or not said losses reflect medical charges covered by the Plan. Recoveries further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

Refund

Repayment to the Plan for medical benefits that it has paid toward care and treatment of the injury or sickness. This right of Refund also applies when a covered person recovers under an uninsured- or underinsured-motorist plan (which will be treated as third-party coverage when reimbursement or subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Subrogation

The Plan's right to assume the place of a covered individual in pursuing rights to recover from a third party who is liable for the individual's loss.

Third party

Any other person or a business entity including, but not limited to, any of the following:

- The party or parties who caused the illness, sickness, or bodily injury
- The insurer or other indemnifier of the party or parties who caused the illness, sickness, or bodily injury
- A guarantor of the party or parties who caused the illness, sickness, or bodily injury
- The covered person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage)
- A workers' compensation insurer
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the act or omission to act, illness, sickness or bodily injury, including, but not limited to, premises medical payments coverage, liability insurance coverage, automobile no-fault or medical payments coverage, uninsured- or underinsured-motorist coverage

Urgent care medical claim

A claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care decisions:

- Would seriously jeopardize the claimant's life, health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested

Optional Continuation of Coverage (COBRA)

Federal law created the right to continue health care coverage after it would otherwise end due to a qualifying event. This applies to some, but not all, of your benefits. See **Continuation of Benefits When Active Coverage Ends** section of the **Eligibility and Enrollment** chapter for a complete description of benefit continuation.

What is COBRA and when is it offered?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most group health plans (including this Plan) offer employees and their families continued health care coverage, if the coverage would otherwise end due to one of the following qualifying events:

- Termination of your employment with Providence Health & Services for any reason except gross misconduct; coverage may be continued for you and your eligible dependents
- A reduction in the hours you work which results in loss of Plan eligibility or a significant premium increase; coverage may be continued for you and your eligible dependents
- You or an enrolled family member becomes entitled to Medicare, which means you are eligible, then enroll in Medicare and drop coverage under this Plan. Coverage may be continued for your eligible dependents
- Your death; coverage may be continued for your eligible dependents
- Divorce or legal separation from your spouse; coverage may be continued for that spouse and your eligible dependents. Note: It is your responsibility to report this event within 60 days of the date the divorce became final or the date the court ruled that you are legally separated
- Loss of eligibility by a covered dependent child because the child no longer qualifies as a dependent; coverage may be continued for that child

COBRA for ABRs

Note: ABRs, ABR Partners and children of ABR Partners are not eligible for COBRA or other continuation coverage if they lose eligibility for active coverage (i.e. if the ABR relationship ends or they become eligible for other medical coverage or an ABR child turns age 26). If the employee loses eligibility (i.e. reduction in hours or other COBRA qualifying event), the employee may continue coverage for the ABRs as part of their own COBRA enrollment.

What health care coverage is available?

Health care coverage available under COBRA Continuation Coverage includes medical, dental, vision, Caregiver Assistance Program and Health Care Flexible Spending Accounts (HC-FSA). You can only continue participation in a HC-FSA on an after-tax basis for the duration of the calendar year if you have funds remaining in your account at the time of your qualifying event. You are not eligible to elect coverage in subsequent calendar years. Special rules may apply in the event of death or divorce.

If you choose to continue coverage, the coverage available will be identical to that provided to similarly situated employees or family members. If the coverage changes for active employees, it will change for you in the same manner. Your COBRA rights are provided, as required by federal law. If the law changes, your rights will change accordingly. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for that coverage before coverage is made available.

Who is a Qualified Beneficiary?

Individuals who are eligible to continue health care coverage are called qualified beneficiaries. A qualified beneficiary is an individual who was covered by the group health plan on the day before the qualifying event occurred and who is an employee, the employee's spouse or former spouse, or the employee's dependent child. Any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary.

While not qualified beneficiaries under statute, Providence Health & Services also allows continued coverage for an ABR and their eligible unmarried children, under the following circumstances:

- Termination of your employment with Providence Health & Services for any reason except gross misconduct, or
- A reduction in the hours you work which results in loss of Plan eligibility or a premium increase, AND
- You elect COBRA coverage for yourself including the ABR and their unmarried children.

More Information about Individuals Who May be Qualified Beneficiaries

Dependents you acquire while on COBRA may be enrolled in the Plan as long as they are added to coverage timely. For birth and adoption, you must notify the COBRA administrator ("BenefitConnect I COBRA") within 60 days of the event. For other dependents, such as those you acquire through marriage, you must also notify BenefitConnect I COBRA within 60 days. The COBRA administrator will comply with Qualified Medical Child Support Orders (QMCSOs) in accordance with the terms of the Plan.

Electing COBRA

Each qualified beneficiary has an independent right to elect COBRA coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your coverage plus a 2% administration fee.

Coverage will be terminated during the election period and will not be reinstated until AFTER you enroll in COBRA and your first payment has been received and processed. Once your election has been processed, your coverage will be reinstated back to the date active coverage ended and eligible claims will then be processed. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE**.

COBRA and Other Coverage

If you have coverage through Medicare or another employer's plan before your qualifying event, you may apply for and enroll in COBRA coverage.

If, after the date of your COBRA election, you obtain coverage through Medicare or another group health plan (which does not include any exclusions or limitations with respect to pre-existing conditions), your COBRA coverage will end. It is your responsibility to report this to BenefitConnect I COBRA.

Maximum Period of COBRA Continuation Coverage

Length of COBRA Coverage	Event	Who
Events that impact eligibility for you and your eligible dependents (including an ABR, ABR Partner and their children as part of your enrollment for COBRA)		
18 months	Loss of benefits due to a reduction in hours or premium increase	You, your eligible dependents, including an ABR, ABR Partner.
18 months	Termination of employment, for any reason other than gross misconduct	You, your eligible dependents, including an ABR, ABR Partner.
Events that impact eligibility for your spouse, if any and child(ren). ABR and ABR Partners are not eligible for COBRA based on these events		
36 months	Eligibility for Medicare, if you become covered less than 18 months before your termination of employment or reduction in hours	Your spouse and eligible dependent child(ren)
36 months	Any other qualifying event, such as divorce, a child becoming ineligible due to age, your death, etc.	Your spouse and eligible dependent child(ren)

Can I extend the length of COBRA Continuation Coverage?

Disability extension of COBRA coverage

If you or any qualified beneficiary who is receiving 18 months of continuation coverage becomes disabled (as determined by the Social Security Administration) before the 60th day of continuation coverage, and that disability continues during the rest of the 18 months of continuation coverage, you and your dependents may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months. To be eligible, all of the following conditions must be met:

- The qualifying event must be the covered employee's termination of employment or reduction of hours; and
- The qualified beneficiary (who may be the covered employee or his or her spouse or dependent child) must be determined under the Social Security Act to have been disabled at any time during the first 60 days of COBRA coverage; and
- The qualified beneficiary must notify BenefitConnect | COBRA of the Social Security disability determination within 60 days after the latest of:
- the date of the Social Security disability determination; or
- the date of the qualifying event; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
- the date on which the qualified beneficiary is informed, through the furnishing of the COBRA election packet, of both the responsibility to provide the notice of disability determination and the Plan's procedures for providing such notice to the plan administrator; AND

If approved for disability

You have 60 days to notify the COBRA administrator of the determination by Social Security of your disability. You can contact BenefitConnect | COBRA to request a copy of the form "Notice of Disability Form" or download it from their website at **https://cobra.ehr.com**

- The qualified beneficiary must notify BenefitConnect | COBRA of the Social Security disability determination before the end of the 18-month period following the qualifying event (i.e., the employee's termination of employment or reduction of hours).

This extension of COBRA coverage ends for all qualified beneficiaries, not just the disabled beneficiary, if the Social Security Administration makes a determination that the disabled person is not or is no longer disabled on the later of (1) the first day of the month that is more than 30 days after the Social Security Administration's final determination that the formerly disabled qualified beneficiary is no longer disabled; or (2) the end of the coverage period that applies without regard to the disability extension. You or your family member must notify the COBRA administrator within 30 days of a determination of non-disability by Social Security.

Second Qualifying Event

If your family experiences another qualifying event while receiving the 18 months of COBRA Continuation Coverage, the spouse and dependent children receiving COBRA coverage can get up to an additional 18 months, for a maximum of 36 months, if notice of the second qualifying event is properly provided to BenefitConnect I COBRA.

This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child is no longer eligible under the Plan, but only if the event would have caused the spouse or dependent child to lose coverage had the first qualifying event not occurred. (This extension is not available when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours because the Medicare entitlement would not have caused a loss of coverage under the Plan if it had been the first qualifying event.)

This extension due to a second qualifying event is available only if you notify BenefitConnect | COBRA online or in writing of the second qualifying event within 60 days after the date of the second qualifying event. When providing notice, you must use the form titled "Notice of Second Qualifying Event Form". You can contact BenefitConnect I COBRA to request a copy of the form or you can download the form from their website at **https://cobra.ehr.com.** Follow the procedures specified in the box titled "Notice Procedures" at the end of the notice. If these procedures are not followed, or if the notice is not provided to BenefitConnect | COBRA during the 60-day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT**.

If an individual experiences more than one qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event. In no case will more than 36 months of continuation coverage be available. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the Plan in the absence of the first qualifying event.

Your notification requirements

You or your dependent must provide notification to BenefitConnect I COBRA in the event of a divorce, legal separation, or a child losing dependent status under the Plan. This notice must be given within 60 days from the date of the qualifying event or the date coverage is lost due to the event. Failure to provide this notification within 60 days will result in the loss of continuation rights and your option to purchase COBRA. If you are a COBRA beneficiary who is reporting a change in relationship status, you must contact BenefitConnect I COBRA at 877-292-6272.

You or your dependents also have the responsibility of keeping the Plan informed of the current address of all participants or beneficiaries under the Plan who are or may become qualified beneficiaries.

How, when, and where to send notice

You may provide notice to BenefitConnect I COBRA via:

Online	**https://cobra.ehr.com**
By Phone	1-877-29-COBRA (26272)
By Mail	BenefitConnect | COBRA Dept: COBRA P.O. Box 981915 El Paso, TX 79998

If mailed, your notice must be postmarked no later than the last day of the applicable notice period.

Information required on all notices

Any written notice you provide must include:

1. the name of the Plan (Providence Health & Services Health and Welfare Plan);
2. the name and address of the employee who is (or was) covered under the Plan;
3. the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event;
4. the qualifying event and the date it happened; and
5. the certification, signature, name, address, and telephone number of the person providing the notice.

Additional information required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying BenefitConnect I COBRA that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to your sponsoring employer that your coverage was reduced or eliminated.

Additional information required for Notice of Disability

Any notice of disability that you provide must also include:

1. the name and address of the disabled qualified beneficiary;
2. the date that the qualified beneficiary became disabled;
3. the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
4. the date that the Social Security Administration made its determination;
5. a copy of the Social Security Administration's determination; and
6. a statement showing whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional information required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must also include:

1. the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
2. the second qualifying event and the date that it happened; and
3. if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who may provide notice

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notice. A notice provided by any of these individuals will satisfy the responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Important Reminder

If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA coverage (or will lose the right to an extension of COBRA coverage, as applicable).

Providence's requirement to furnish notices

The COBRA rights provided under this Plan are described in this summary plan description. In addition, group health plans must give each employee and spouse who becomes covered under the Plan, a general notice describing COBRA rights. The general notice must be provided within the first 90 days of coverage and must include plan information, a general description of the continuation coverage available under the Plan, an explanation of what qualified beneficiaries are required to do in the event of disabilities and other qualifying events. The Plan must also provide an explanation of the importance of keeping the plan administrator informed of current address information for the participants in the Plan.

After receiving notice of a qualifying event, the Plan must provide the qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice includes all of the Plan details (name, address and phone number of the COBRA administrator), information about the qualifying event and identification of the qualified beneficiaries as well as the date coverage will terminate if continuation coverage isn't elected, how to elect continuation coverage, and what will happen if continuation coverage isn't elected or is waived. Additional information such as the procedures involved with coverage, when premiums are due, and how long coverage can continue is also provided.

Cost of COBRA Continuation Coverage

You are responsible to pay for COBRA Continuation Coverage, which is generally 102% of the full cost of the coverage. This cost may differ from the premium rates for coverage as an active employee. Rates are established by the Plan and are subject to change when necessary due to plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event. Coverage must be continuous.

After the initial premium is paid, failure to make payment within 30 days of the due date will result in the permanent cancellation of continuation coverage.

When COBRA Continuation Coverage Ends

Continuation of coverage ends on the earlier of:

- The date the maximum continuation period expires
- The date the covered individual first becomes covered by Medicare, after the date of the COBRA election (although this does not affect dependent eligibility)
- The date the covered individual first becomes covered under another group health plan (unless that plan contains any exclusion or limitation with respect to a pre-existing condition of the individual who is continuing coverage) after the date of the COBRA election
- The last period for which payment was made when coverage is canceled due to non-payment of the required cost
- The date Providence Health & Services no longer offers a group health plan to any of its employees
- The date of recovery, in case of an extension for Social Security determined disability (You must notify the Plan Administrator within 30 days of the Social Security determination of recovery.)

A dependent's COBRA coverage ends when the original qualified beneficiary's coverage ends. At that point, the dependent then becomes a qualified beneficiary with independent rights to elect COBRA. (This does not include Adult Benefit Recipients.)

When COBRA coverage ends, you may wish to consider other insurance resources such as a policy available through the Marketplace Exchange.

Questions

Contact BenefitConnect | COBRA (1-877-292-6272) if you would like further information and more details regarding the continuation of coverage (COBRA).

Alternatives to COBRA Continuation Coverage

Those enrolled in COBRA Continuation Coverage may have alternatives for coverage that may be more affordable or more generous.

Special enrollment in an alternate health plan

One option may be "special enrollment" in other group health coverage. Under the Health Insurance Portability and Accountability (HIPAA), upon certain events, group health plans and health insurance issuers are required to provide a special enrollment period during which individuals who previously declined coverage for themselves and their dependents, and who are otherwise eligible, may be allowed to enroll without having to wait until the next open enrollment. The event that triggers special enrollment is an employee or dependent of an employee losing eligibility for other health coverage. For example, if you lose group health coverage you may be able to special enroll in a spouse's health plan. You or your dependent must request special enrollment within 30 days of the loss of other coverage.

Health Insurance Marketplace

Losing employment-based health coverage also gives the employee an opportunity to enroll in the Health Insurance Marketplace (Marketplace) that serves the state in which you reside. The Marketplace offers "one-stop shopping" for individuals to find and compare private health insurance options.

In the Marketplace, you may be eligible for cost-sharing reductions and a tax credit that lowers monthly premiums. Being offered COBRA Continuation Coverage does not limit eligibility for coverage or for a tax

credit through the Marketplace. You or your dependent must elect Marketplace coverage within 60 days before or 60 days after the loss of other coverage, or you will have to wait until the next Marketplace open enrollment period.

Through the Marketplace, you can determine whether you or your dependents qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). Eligible individuals can apply for and enroll in Medicaid and CHIP at the same time. For more information about Marketplace coverage, including information about Medicaid or CHIP eligibility, visit **healthcare.gov.**

If you or your dependent chooses to elect COBRA, you or your dependent will have another opportunity to request special enrollment in another group health plan or the Marketplace once COBRA is exhausted. In order to exhaust COBRA coverage, you must receive the maximum period of COBRA coverage available without early termination. You must request special enrollment within 30 days of the loss of COBRA coverage for coverage through another group health plan or select a plan within 60 days before or 60 days after the loss of COBRA coverage, for coverage through a Marketplace plan. If you or your dependent chooses to terminate COBRA coverage early with the special enrollment opportunity at that time, you will have to wait to enroll in other coverage until the next open enrollment period of another group health plan or the Marketplace.

Caregiver Assistance Program

Overview

Well-being is more than just physical health. The Caregiver Assistance Program, provided through Lyra, is a confidential resource for you and your dependents. The program covers a wide range of day-to-day concerns, as well as issues that may have a negative effect on your work or personal life.

The Caregiver Assistance Program provides confidential information, guidance and support to help you and your family reach your goals, manage daily stresses and develop fulfilling relationships. Consultants or counselors may help you develop a plan, as well as offer direct services and referrals for further assistance.

Services include:

- 24-hour access to trained professionals
- Assessment and referral
- Work Life Services Consultation
- Legal and financial consultation
- Online resources and tools

Taking advantage of this program is voluntary, and services are provided at no cost. You do not have to enroll for coverage; you and your dependents are automatically covered as of your date of hire.

Eligibility

All caregivers are eligible, including full-time, part-time, per diem and on-call caregivers. Eligible dependents are your legal spouse, Adult Benefits Recipient (ABR), your children, your stepchildren, your ABRs unmarried children, or any individual who is part of your household. The Plan also covers children living away from your home (away at school or for which there is a court order for coverage).

Caregiver Assistance Program Counseling Services

If you or a family member needs counseling services, call the Caregiver Assistance Program at 844-311-6223 any time, day or night. Depending on your situation, you may receive:

- A referral and authorization to a licensed network provider in your community for up to twenty-five (25) in-person or virtual counseling sessions, per rolling 365-day period, at no cost to you or your dependent
- Brief “solution focused” counseling over the phone or through a secure video at no cost to you
- Referrals to additional program features through the Caregiver Assistance Program at no cost to you
- Recommendations and referrals to available resources in your community
- In certain circumstances, you may be referred to additional services that extend beyond the scope of the Caregiver Assistance Program.
- For referrals and recommendations, you are responsible for any costs associated with additional services. Examples include the cost of dependent care, elder care and other community services, and services by an attorney beyond the initial consultation or treatment.
- If your situation requires it, your counselor may refer you for additional treatment or sessions beyond your Caregiver Assistance Program coverage. Generally, the additional services are part of the behavioral health care or medical coverage through your medical plan.

- Any charges for services outside the Caregiver Assistance Program are subject to the terms of your medical plan coverage and may include out-of-pocket deductible and coinsurance charges. If you are not covered by a medical plan, you will pay the full cost for any additional treatment or sessions.

Note: Some services covered by the Caregiver Assistance Program require authorization. You will be responsible for paying for these services if you do not seek authorization prior to seeking care.

Confidentiality

The Caregiver Assistance Program upholds strict confidentiality standards. Your personal information is kept confidential in accordance with federal and state laws. No one will know you have accessed the program services unless you specifically grant permission or express a concern that presents a legal obligation to release information (for example, if it is believed you are a danger to yourself or to others).

Work Life Services Consultation

The Caregiver Assistance Program also offers Work Life Services Consultation providing professional telephonic support and referral help for a wide spectrum of work, family and personal issues and life events including:

Daily Living

- Travel and recreation
- Dining and entertainment
- Consumer issues
- Household maintenance and repair
- Pet care
- Community resources
- Health and wellness

Child Care

- Choosing child care
- Summer/holiday care
- Special needs child care
- Community resources

Adult Care

- Care for older adults
- Special needs adult care
- Navigating Medicare and Medicaid services
- Support for those responsible for adult or elderly parent

Family Support

- Parenting
- Adoption
- Pregnancy and infertility information
- Talking to teenagers

Education

- K-12 information
- Information on colleges and universities
- Financing
- GED/vocational
- Tutors and test preparation

Career

- Job placement, training and educational resources in your community

Legal and Financial Solutions

The Caregiver Assistance Program provides a free initial consultation with an attorney and/or a financial professional. You are responsible for all fees beyond the free initial consultation.

The attorneys and financial professionals will assist you with most situations, but some restrictions do apply.

Legal Solutions

You have access to one free office or telephone-based initial consultation with an attorney for each separate legal matter. The duration of the consultation varies depending on the issue. Consultations for family law, the most common type of consultation, are 60 minutes in duration. The national network includes attorneys with experience in a variety of legal areas including bankruptcy, estate planning, taxes, family law, consumer and financial matters, and traffic violations.

If you decide to retain (hire) the attorney, you will receive a 25 percent discount on the attorney's usual hourly rate. The discount is 35 percent for issues related to family law. This service helps with legal matters such as:

- Alimony
- Child support
- Adoption
- Living wills
- Powers of attorney
- Foreclosures

Mediation Services

Mediation services can save you time and money as well as give you greater control over the outcome of your dispute. You will receive one free 30-minute consultation per issue with a mediation professional. If additional services are needed, you will receive a 25 percent discount on the mediator's usual hourly rate.

A mediator can assist in resolving cases such as:

- Divorce and child custody
- Contractual and consumer disputes
- Real estate and landlord-tenant issues
- Car accidents and insurance disputes

Financial Consultation

Financial professionals provide free telephonic consultation on the financial topics that are important to you. Online resources include articles, financial calculators and other handy budgeting tools. The financial professionals provide help with:

- Budgeting
- Credit matters
- Estate planning
- Retirement planning
- College funding
- Investment subjects
- Tax issues
- Insurance-buying strategies
- Debt counseling
- Divorce planning
- Bankruptcy

Note: Providence provides no warranties or representations regarding the quality of services provided by each individual attorney or financial professional.

The Caregiver Assistance Program Website

Visit the Caregiver Assistance Program website at **caregiver.lyrahealth.com** to access information about Lyra services and programs, FAQs, registration link, Work-life service information and links and an introductory video.

Accessing Services

You can reach the Caregiver Assistance Program by phone at 844-311-6223, 24 hours a day, seven days a week. You will need to provide sufficient information, as determined by the Plan Administrator, to prove eligibility when contacting the Caregiver Assistance Program administrator, Lyra. Master's level, clinical care managers are available 24 hours a day, seven days a week.

You can access the Caregiver Assistance Program website at **caregiver.lyrahealth.com.** You can access the site 24 hours a day, seven days a week.

Claims

You and your dependents are not required to pay for any services provided through the Caregiver Assistance Program, so you do not have to file claims. You should not make any agreement with a Lyra counselor to pay for services covered by the program. However, you or your dependent will be responsible to pay for any services obtained from a particular Caregiver Assistance Program counselor without receiving prior authorization from Lyra. You are also responsible to pay for any continued outpatient therapy sessions beyond the twenty-five sessions covered by the Caregiver Assistance Program, financial services or legal services beyond the free initial consultation, and fees related to any community-based resource or service.

When Coverage Ends

- Your coverage and your eligible dependents' coverage under the Caregiver Assistance Program will end:
- The last day of the month in which your employment ends with the company, including due to your retirement or in the event of your death (except as provided under any applicable law).
- The Plan ends. Coverage for you and your eligible dependents ends on the date the Caregiver Assistance Program terminates.

Exclusions and Limitations

Certain services are specifically excluded from coverage provided under this plan including, but not limited to:

- Employment law issues – no advice will be offered on disputes between employees and employers.
- Corporate law – questions relating to corporate law, including those generated from employee or spousal-owned businesses will not be answered.
- Second opinions – advice will not be given on how another attorney is handling a legal situation or rendering a subsequent opinion in case law.
- Third-party callers – participants cannot seek advice to help with someone else's legal problems.
- Investments – financial professionals will not provide advice regarding specific investment vehicles such as stocks, bonds, or mutual funds. They can, however, provide advice on investment strategies.

Life and Accident Insurance

Insurance Certificate

Life and AD&D benefits are fully insured plans administered by Securian. As such, the insurance ***certificate*** "Certificate" governs the terms of the coverage. You may access the ***HR Service Portal*** for a copy containing additional details about your coverage.

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this.***

Overview

Life Insurance and Accidental Death and Dismemberment (AD&D) benefits provide financial protection in the event of death or serious ***injury*** to you or your covered dependent. This coverage can be an important element of long-range planning for you and your family, so Providence provides basic coverage to employees at no cost. You may also be eligible to purchase supplemental coverage for yourself and for eligible dependents. Life and AD&D benefits are provided through Securian.

The following chart summarizes the benefits covered by each plan, which are described in more detail in this chapter including the amounts of coverage. Benefits are paid to you or your ***beneficiary*** in the event of your death.

Under the…	Available for…	What you pay…	Benefits May be Payable…	Amount of Coverage
Basic Employee Life Insurance Plan	Eligible employees	Providence pays the full cost of this coverage. Note: The value of coverage over $50,000 will be subject to ***imputed income*** in accordance with Internal Revenue Service regulations.	If you die for any reason	• Staff receives 2X your annual pay, up to $400,000 • Leaders and above and providers receive 2X your annual salary, up to $1,000,000. Note: If your coverage exceeds $50,000, you have the option to change from your existing volume to $50,000 to avoid ***imputed income***.
Supplemental Employee Life Insurance Plan	Eligible employees	You pay the full cost of coverage at group rates.	If you die for any reason	1 – 6X your annual base pay, multiplied up to $1 million
Spouse Supplemental Life Plan	Your eligible spouse or ABR	You pay the full cost of coverage at group rates.	If your spouse or partner dies for any reason	Amount available $10,000 - $250,000 in $10,000 increments
Child Supplemental Life Plan	Your eligible children or children of your ABR	You pay the full cost of coverage at group rates.	If your child dies for any reason	Non-represented employees:, Child life coverage is a flat $20,000

Employee Supplemental AD&D*	Eligible employees	You pay the full cost of coverage at group rates.	Your death due to a covered accidental ***injury, Paralysis,*** brain damage, coma or ***loss*** of your ***limbs***, eyesight, hearing or speech due to a covered accidental injury	1 – 10x your annual base pay, up to $1 million
Spouse Supplemental AD&D	Your eligible spouse or ABR			Amount varies Multiples of $10,000 up to $500,000
Child AD&D	Your eligible children or the children of your ABR			$20,000

*Some employees may have access to Basic AD&D; check the ***HR Service Portal*** for additional information

General Life Insurance Information

Plan Definitions

At the end of the Life Insurance chapter, you will find a **Glossary** that defines terms in this chapter that are formatted in bold and italic ***like this***.

Eligibility

The following requirements apply to when you or your dependents may be eligible for Life and AD&D coverage:

Note: Additional eligibility requirements apply. Please review the Eligibility and Enrollment chapter for more information.

Employees

"Actively at Work" Provision

You must be actively at work to be covered by Life and AD&D benefits. If you are absent from work due to sickness or ***injury*** on the date of eligibility or the effective date of coverage, your eligibility date or effective date will be deferred until you return to work.

This will also apply to any increase in your coverage. In addition, you must be performing all of the usual and customary duties of your job at your normally scheduled weekly hours at one of the following:

- Your regular Providence Health & Services work location
- An alternate place approved by Providence Health & Services
- A place to which Providence Health & Services requires that you travel

You will be deemed to be "actively at work" during weekends or Providence-approved vacations, holidays or business closures if you were actively at work on the last scheduled work day preceding such time off.

Dual Coverage

If you and your spouse/Adult Benefits Recipient (ABR) are both employed by Providence, each of you may purchase Supplemental Employee Life Insurance. You may also each purchase Spouse Life Insurance or AD&D coverage for your spouse/Adult Benefits Recipient (ABR). If you and your spouse/ABR are both employed by Providence or one of its ***affiliates***, you are both permitted to cover your dependent child(ren), as the plan permits dual coverage for your eligible dependent children who are not employed by Providence.

Note: If you and your adult child are both benefits-eligible employees of Providence or its affiliates, your adult child is no longer eligible for coverage under the Dependent Life Insurance plans.

Dependents

The following sections provide the eligibility requirements that apply to Dependent Life and AD&D coverage. Similar to the actively-at-work requirement for employees, on the day that the dependent coverage takes effect, your eligible dependent must not be:

- Confined at home under a doctor's care, or
- Receiving or applying to receive disability benefits from any source, or
- Hospitalized

Coverage begins when the disabling condition is no longer applicable.

Spouse

All legal spouses are eligible to be covered under the Supplemental Spouse Life plan and are eligible for enrollment in Supplemental Spouse AD&D. For details on coverage availability, log on to the ***HR Service Portal*** to learn more.

Adult Benefits Recipient (ABR) Domestic Partner

A person has an "insurable interest" in something when loss or damage to it would cause that person to suffer a financial loss or certain other kinds of losses. Qualified domestic partners meet the definition of "insurable interest" while other adult dependents, such as a parent, or other relatives, do not. Therefore, you can cover your legally qualified spouse or your same or opposite gender domestic partner, but not other Adult Benefits Recipients.

Note: Your spouse coverage for life and AD&D insurance must not exceed the amount of your own life and AD&D insurance, per regulatory requirements. To determine this, a) add your Basic and Supplemental Life and AD&D coverage. Then b) add your Spouse Life and AD&D coverage. The amount in b) may not exceed the amount in a).

- For dependent life and AD&D insurance, your ABR (domestic) Partner is defined as your same or opposite sex partner, whom you present publicly as your domestic partner. Your domestic partner is eligible for dependent life insurance coverage if he or she:
- Has registered as a domestic partner or member of a civil union with a government agency or office where such registration is available, or
- Is a member of your household, i.e., a person who is part of the family unit and intends to remain so for the foreseeable future; someone with whom you have a close personal relationship, for whom you provide financial support, and with whom you are committed to a relationship of mutual caring; this does not include a renter, roommate or other person living in the home on a casual basis, and

- You have submitted a declaration to Providence establishing that you and your domestic partner:
  - Have each attained 18 years of age or older and have shared the same residence for at leas12 months prior to the date you enroll him or her for the domestic partner coverage under the group policy
  - Are unmarried
  - Have not had another domestic partner within 12 months prior to the date you enroll him or her for the domestic partner coverage under the Plan
  - Are not related by blood in a manner that would bar your marriage in the jurisdiction in which you reside
  - Have an exclusive mutual commitment to share the responsibility for each other's welfare
  - Have shared financial obligations for at least 12 months prior to enrolling for coverage under the Plan, and such commitment is expected to last indefinitely
  - Two or more of the following may be required as evidence of joint responsibility for basic financial obligations:
    - A joint mortgage or lease
    - Designation of the domestic partner as beneficiary for life insurance or retirement benefits
    - Joint wills or designation of the domestic partner as executor and/or primary beneficiary
    - Designation of the domestic partner as durable power of attorney or health care proxy
    - Ownership of a joint bank account, joint credit cards or other evidence of joint financial responsibility
    - Other evidence of economic interdependence

IMPORTANT!
The Statement of Health process may require that you provide medical records or see a doctor. There are multiple steps involved in the approval process, in some cases. **It is important that you immediately begin the Statement of Health process following your request for increased coverage at the time of enrollment. Your completed Statement of Health should be submitted to Securian within 30 days of being notified of the requirement.**

For benefit plan coverage, a declaration on file with a Providence designee, is required to substantiate or complete the dependent eligibility requirements at the time of enrollment.

Note: ABRs are eligible to be enrolled for Life and AD&D coverage when you enroll for the first time as a newly hired or newly benefits-eligible employee, during Open Enrollment and when you have a qualifying event that allows for enrollment or changes to enrollment in this benefit. The children of qualifying Domestic Partners are also eligible for dependent life and AD&D coverage.

Child

You are eligible to cover your child under the Supplemental Child life benefit and you may also enroll your child in Supplemental Child AD&D. Your child includes your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption), unmarried foster child and stepchild (including the child of an eligible ABR who is under age 26). Note: Dependent child coverage may be continued past the age limit if the child is incapable of self-sustaining employment because of a developmental disability, mental or physical handicap, as defined and approved by Providence.

This also includes attainment of the legally appointed guardianship for a dependent child or a judgment, decree or court order requiring you to provide benefit coverage for a dependent child, until the age stipulated in the guardianship or court order, as allowed under the terms of the Plan.

Your child is not eligible for coverage if:

- He or she is insured through Providence or an ***affiliate*** as an employee

Leave of Absence

Depending on the type of leave, life insurance may continue for a period of time during your leave of absence with Providence.

If you return from your leave within 30 days of when your benefits ended, your benefits are reinstated. If you return after 30 days, you will be given an opportunity to reelect your benefits. You will be subject to Statement of Health criteria, if applicable. If you do not return from leave, coverage ends for you and your dependents unless you elect to port or convert your coverage while on leave. Please see the **Termination of Coverage** section for more information.

Note: Contact the Benefits Service Center for information about continuing your life insurance coverage while on an approved leave.

Coverage if Totally Disabled/Premium Waiver

If you become totally and permanently disabled while insured before age 60, your Supplemental employee life insurance in force at the time of your disability can be continued without cost until age 70, upon Securian's approval of your ***premium waiver*** application. This approval is automatic if you have also been approved for a Providence Long Term Disability claim. This coverage continues until age 70, or the date when you are no longer disabled, or the date you fail to comply with Securian or NYL's request for medical information, whichever is earlier. When you turn 70, you may convert your coverage to an individual policy. This provision does not apply to employee AD&D, dependent life, or dependent AD&D coverage. Please review the **Conversion** section for more information.

Annual Base Pay

Your life insurance is based upon your ***annual base pay***. This is your current base rate of pay, as reflected in the payroll system, unless you work as a provider, an alternate compensation model is used if it will provide a greater benefit. It does not include income from commissions, bonuses, overtime pay, or any other extra compensation or income received from sources other than Providence.

For providers. The amount of your life insurance is based on the greater of a) the above definition, including any medical directorship pay you are eligible to receive or b) if you have been employed in your position for 12 consecutive months or more, your total earnings for a rolling twelve-month period.

It includes all pay resulting from the performance of duties for Providence, including productivity pay and any medical directorship pay. It does not include signing bonuses, educational costs, licensure costs and similar items.

Evidence of Insurability/Statement of Health

Supplemental employee life insurance and spouse/ABR dependent life insurance may require evidence of insurability, referred to as a Statement of Health (SOH), which involves answering health questions and, in some situations, providing documentation of your current health status. Securian evaluates the information you submit to determine if you meet their underwriting requirements to issue or increase coverage. Effective January 1, 2022, a SOH is required if you had previously elected "in lieu" coverage and are now returning to full benefits coverage.

Note: A Statement of Health is not required for Basic Employee Life Insurance, AD&D coverage or Child Life Insurance. If an employee has elected to reduce their Basic Employee Life Insurance to $50,000, they must submit a SOH for approval if they later decide to increase their coverage.

When you first enroll, a Statement of Health is required for employee coverage above four times your ***annual base pay*** or $500,000, whichever is less.

As long as you are already enrolled for coverage, you may increase your coverage amounts by one multiple of your annual base pay up to this same limit (four times your annual base pay or $500,000, whichever is less), without a Statement of Health during open enrollment or due to a qualifying event. A Statement of Health is required for spouse/domestic partner coverage over $50,000, when initially eligible. You may increase spouse/domestic partner coverage by increments of one level up to this same limit without a Statement of Health. Some scenarios of when a Statement of Health is required are provided in the table below. For additional information, see ***Certificate*** if you do not see your situation described below.

When Statement of Health is Required	
When you are initially eligible…	**During Open Enrollment or due to a qualifying event…**
Coverage over 4X your annual base pay or $500,000, whichever is less (Amounts available: 1 – 6X base annual pay)	• If coverage was previously not elected, any elected coverage amount. • For increase in coverage of more than 1X your annual base pay up to 4X your annual base pay, or $500,000, whichever is less. • For any coverage greater than 4X your annual base pay or $500,000, whichever is less
When your spouse/Adult Benefits Recipient is initially eligible…	**During Open Enrollment or due to a qualifying event…**
For coverage exceeding $50,000 (Increments available: $10,000 to $250,000)	• If coverage was previously waived, for any election exceeding $10,000. • For any amounts that exceed one-level increase from the previously approved level of coverage, up to $50,000. • For any coverage greater than $50,000.

Changing your Coverage

You may add Supplemental Life and AD&D insurance coverage for you and/or your dependents if you become newly eligible for benefits.

In most cases, you may only change your Life and AD&D coverage elections during Open Enrollment or as a result of certain qualifying events. See the Qualifying Events section in the Eligibility and Enrollment chapter for other changes.

Note: If you increase life insurance coverage for you or your spouse/domestic partner, you may be required to submit a Statement of Health. For more information, please review the Evidence of Insurability/Statement of Health section.

Effective date of coverage

The changes you make due to a qualifying event, or enrollment due to new eligibility, take effect as follows:

- For amounts that do not require a Statement of Health, coverage is retroactively added as of the date of the event.
- For amounts that do require a Statement of Health, the amount that is not subject to underwriting is retroactively added to your benefits on the event date. The remaining amount is held in a pending state until the insurance company has performed their review. If approved, Providence and you are notified, and coverage is added as of the date of coverage approval. Increased premium deductions occur on your first paycheck following the approved increase in coverage. Your completed Statement of Health should be submitted to Securian within 30 days of being notified of the requirement. Be sure to review your benefits regularly to confirm your coverage.

Marrying your ABR?

If you have an ABR Health and/or Life or ABR Partner, whether they were covered under the life insurance plan or not and you later marry, this is not an event that permits you to add or increase coverage for them. Their relationship as your ABR was the event that created initial eligibility.

Disability

If you are disabled and away from work, you can change your coverage for yourself or your dependents during your leave due to a qualifying event or open enrollment, but the changes will not become effective until you return to work.

More Information

Please refer to the **When Can I Enroll or Change My Elections** section in the **Eligibility and Enrollment** chapter for more information.

Designation of Beneficiary

You will be asked to name a ***beneficiary*** for your life insurance and AD&D coverage. You may change your beneficiary at any time by updating information in the ***HR Service Portal***.

The beneficiary may be one person, several people, a trust, a charity or your estate.

Before naming a beneficiary, you may wish to contact your attorney for advice. If you name a trust, an estate, or a minor child, your attorney will guide you through the process to ensure the claim is paid according to your wishes. If you do not name a beneficiary, any employee life or AD&D benefit payable is made in accordance with a line of succession specified in the insurance ***certificate***. You are the beneficiary for dependent life coverage.

When Benefits are Payable

Life Insurance Benefits

Life insurance benefits are payable in the event of the covered person’s death for any reason.

Benefit Reductions

When you reach certain ages, your basic life insurance benefits will be reduced as described in the table below. The age reduction will go into effect January 1 of the year following the year in which you reach the age listed. (The reductions are not applicable for Supplemental Life and Spouse Life).
Note: If you previously reduced your basic life benefit to $50,000, to avoid ***imputed income***, the age reductions are not applicable unless the basic life benefit would have been less than $50,000.

Age	Benefits Reduced To
70	65% of the full benefit amount
75	45% of the full benefit amount
80	30% of the full benefit amount

Accelerated Death Benefit

If you or a covered dependent is diagnosed as terminally ill (with a life expectancy of 24 months or less), you may apply for an accelerated benefit payment from your Employee or Dependent Life Insurance of up to 100% of the coverage amount in force, subject to limitations, such as the minimum amount of $20,000 or the maximum amount available from all sources, which is $1,000,000. The Plan requires the following as proof of terminal illness:

- A completed accelerated benefit claim form
- A signed physician's certification that you or your covered dependent is terminally ill
- An examination by a physician of Securian's choice, at their expense, if requested. This benefit will reduce the life insurance death benefit.

If you, as the employee, elect to take 100% of your life insurance benefit, you will no longer be a participant in the life insurance plan and as such, coverage for your dependents will also end. If you elect to take 100% of your spouse's accelerated death benefit, your spouse's participation in the life insurance plan ends. If you or your spouse do not elect to take the full 100%, you remain a participant, but you are no longer permitted to increase your life insurance coverage through annual enrollment or other qualifying events.

Note: The accelerated death benefit may be taxable. As with all tax matters, you should consult with a personal tax advisor to assess the impact of this benefit.

Accidental Death and Dismemberment (AD&D)

AD&D benefits are payable upon certain accidental injuries or events that results in ***loss*** of life or other losses, as shown in the table below. If death or dismemberment due to a covered ***accident*** occurs within 365 days of the accident, the Plan pays benefits as described.

Loss	Benefit Payable
Life	100% of Coverage Amount
Loss of speech and hearing	100% of Coverage Amount
Brain damage	100% of Coverage Amount
Loss of any combination of hand, foot, or sight of one eye	100% of Coverage Amount
Loss of hand Loss of foot	50% of Coverage Amount

Loss	Benefit Payable
Loss of sight in one eye	
Loss of an arm Loss of a leg	75% of Coverage Amount
Paralysis of both upper and lower limbs (***quadriplegia***)	100% of Coverage Amount
Paralysis of both lower limbs (***paraplegia***)	75% of Coverage Amount
Paralysis of both upper & lower limbs on one side (***hemiplegia***)	50% of Coverage Amount
Paralysis of one arm or leg	25% of Coverage Amount
Loss of speech or loss of hearing	50% of Coverage Amount
Loss of thumb and index finger of same hand	25% of Coverage Amount
Coma	1% of Coverage Amount, beginning on the 7th day, per month, to a maximum of 100 months.

Additional Benefits

In the event of a covered loss, additional AD&D benefits may be available. See the group ***certificate*** for details concerning seat belt benefits, air bag use, motorcycle helmet use, resources for surviving spouses and children and more.

Filing and Payment of Claims

To file a claim, you or your ***beneficiary*** should contact the Benefits Service Center.

For life insurance, the benefit will be payable to your designated beneficiary upon satisfactory proof that your death occurred while you were insured. If you have a dependent life claim, the life insurance benefit will be payable to you.

For ***accident*** coverage, the benefit will be payable to you. In the event of your accidental death, the AD&D benefit will be payable to your designated beneficiary upon satisfactory proof that your death occurred while you were insured and was due to a covered accident.

All benefits are produced and paid by Securian, in accordance with their practices. In order for benefits to be payable, you must cooperate with the carrier and supply all required documentation. The carrier will follow-up directly with you at your contact information of record.

Exclusions

Life insurance benefits are payable for your death or your covered dependent's death for any reason. However, Accidental Death and Dismemberment (AD&D) benefits will not be paid for ***loss*** directly caused by any of the following:

- Self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
- Suicide or attempted suicide, whether sane or insane; or
- Your participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
- Bodily or mental infirmity, illness or disease; or
- The use of alcohol; or
- The use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gasses, fumes or other substances taken, absorbed, inhaled, ingested or injected; or

- Motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
- Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury; or
- Medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
- Travel in or descent from any aircraft, except:
  - As a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft; or
  - Acting in the capacity as a paramedic, nurse, physician, medivac team member or other medical staff while on payroll or while employed with the policyholder
- War or any act of war, whether declared or undeclared

Termination of Coverage

Your coverage will cease at the end of the month in which:

- You are no longer benefits-eligible
- You terminate employment
- You are no longer a member of the eligible group
- The premium is not paid when due
- The group policy is terminated

Portability and Conversion

You may continue your basic life, supplemental, dependent and AD&D under any circumstances. When you become ineligible for coverage, such as when you leave Providence, you may continue basic life, supplemental life and dependent life insurance through portability or conversion. Generally, portability allows you to continue the group life policy to a personal term life policy. Conversion allows you to convert the life coverage to a whole life policy. See the chart below to learn more about the differences.

Portability and Conversion Rights		
Feature	**Portability**	**Conversion**
Age	Can continue up to age 70	Can continue past age 70
Cost	Term life is generally less costly than whole life, so premiums may cost less under this option, however premiums increase as you age	Whole life premiums are more costly but remain stable through lifetime
Cash value	No cash value*	Accumulates cash value
Range of amounts	Minimum for employee is $10,000; for a dependent's life is $1,000 Maximum is the amount that was in force on the insured's portability date, but not more than $1,000,000 for an employee or $250,000 for a spouse	

*Cash value is an accumulation of a portion of your premiums that may be available as a savings vehicle for your use during the policy period or upon cancellation.

Shortly after your benefits terminate, you will receive a mailing from Securian to your home mailing address on file with us that outlines your portability and conversion options, with associated costs. It is your responsibility to review this information and respond within required timeframes as well as ensuring we ha your correct home mailing address on file.

Portability

Your group life insurance coverage, including Basic Life, Supplemental Life and AD&D coverage for employees and dependents are portable at group rates until age 70 if you:

- Terminate
- Experience layoff or leave
- Become ineligible for benefits

If you cease active work for the organization based on a disability, you may have continuation rights. See Supplemental Employee Life Insurance.

You must apply for portability or for conversion and remit your first premium within 60 days after group coverage ends. If you are age 70 or older, your option for continued life insurance coverage is via conversion.

Coverage may continue at the current level or be reduced as specified in the policy without taking the medical examination that would normally be required for new insurance.

For those employees and dependents who are already covered under the portability option, there is no impact if the Master Contract is terminated. However, if the Master Contract is terminated, active employees and dependents who are covered under the supplemental employee and dependent life insurance coverages are not eligible for portability. The conversion option is still available.

Conversion

If your Basic Employee Life, Supplemental Life, Spouse/Adult Benefits Recipient Life, Dependent Life and Child Dependent Life coverage reduces or stops for any reason other than non-payment of the premiums when due, you have 60 days to convert your coverage, and remit your first payment, to an individual policy.

Coverage may be converted to any permanent individual life insurance policy that the insurance company offers up to the existing coverage amount without having to provide evidence of insurability. You may not convert Accidental Death & Dismemberment.

If the group policy or Providence participation terminates, only a limited conversion benefit will be available. **You must apply for and pay your first premium for conversion within 60 days after group coverage ends.**

Basic Employee Life Insurance

If you are a benefits-eligible employee, you are automatically provided with Basic Life insurance at no cost to you.

Your Coverage

Providence provides you with basic life insurance coverage generally equal to two times your annual base pay, up to specific plan maximums, as noted below.

Basic Life Amount Benefit	
Staff	Two times annual earnings, rounded up to the next $1,000, with a minimum of $20,000 and a maximum of $400,000
Staff earning $200,000 or more per year and providers	Two times annual salary, rounded up to the next $1,000, up to $1,000,000

*Some employees may also receive Basic AD&D insurance, per union contract. Refer to the ***HR Service Portal*** for additional information.

Please refer to the **Glossary** section for more information. You may also contact the Benefits Service Center or log on to the ***HR Service Portal*** to review your current basic life and AD&D coverage.

Imputed Income

If the amount of your Basic Life Insurance coverage exceeds $50,000, you will be subject to ***imputed income*** in accordance with Internal Revenue Service regulations. This means that for the amount that exceeds $50,000, Providence adds the non-cash income for the value of that additional coverage to your taxable wages; as with all income, this amount is subject to normal income tax withholding.

You may elect to reduce your Basic Life benefit to $50,000, to avoid ***imputed income***. You have the opportunity to make this election at the time you are initially benefits eligible, as the result of a qualifying status change, or during open enrollment.

If you later wish to increase your Basic Life benefit to the standard benefit, you will be subject to a Statement of Health for the difference between $50,000 and the amount of the increase and will again have ***imputed income*** associated with your coverage.

Supplemental Employee Life Insurance

Your Coverage Options

You may purchase up to $1,000,000 in supplemental life insurance coverage in multiples of your ***annual base pay***, rounded up to the next $1,000. Your coverage may not exceed six (6) times your annual base pay. Or you may choose to waive (decline) coverage. Directors and above may purchase up to $1,000,000 in supplemental life coverage in multiples of annual base pay rounded up to the next $1,000. Coverage may not exceed six (6) times annual base pay.

Note: Your elections may be subject to a Statement of Health. Please refer to the Evidence of Insurability/Statement of Health section for more information.

Supplemental Employee AD&D Insurance

Your Coverage Options

You may purchase up to $1,000,000 in Supplemental AD&D Insurance coverage in multiples of your ***annual base pay***, rounded up to the next $1,000

You can log on to the ***HR Service Portal*** for additional details about your options. Employees may elect 1 – 10 times base annual pay. Alternatively, you may choose to waive coverage.

If death or dismemberment due to a covered ***accident*** occurs within 365 days of the accident, the Plan pays benefits for loss of life or other losses. No more than the elected amount will be paid for all losses sustained by an insured individual while the group policy is in effect.

When Benefits Are Payable

Please review the **When Benefits Are Payable** section in this chapter for more information about the benefits available under this Plan. Please also refer to the **Exclusions** section for additional information.

Dependent Life and AD&D Insurance

You may choose among the following coverage options for your eligible dependents:

- Dependent Life for your spouse/Adult Benefits Recipient (ABR) Partner/ABR Health and/or Life
- Accidental Death and Dismemberment for your spouse/ABR Partner/ABR Health and/or Life
- Dependent Life for your child(ren)
- Accidental Death and Dismemberment for your child(ren)
- You may also choose to waive one or all these coverage options

Note: Certain eligibility requirements apply. Please refer to the Eligibility and Enrollment chapter for more information.

Spouse/ABR Insurance

Supplemental Spouse Life Coverage

The Plan offers spouse/ABR Life Insurance in amounts from $10,000 to $250,000[2], in $10,000 increments. This coverage is available to your spouse or your domestic partner referred to in other parts of this document as ABR Partner. Within this coverage, you may see “ABR Partner” and ABR Health and/or Life” designation referred to as domestic partner. You also may choose to waive coverage.

You may elect spouse coverage equal to 100% of the total amount of your life insurance coverage (Basic plus Supplemental plus AD&D coverage) or $250,000, whichever is less. You also may choose to waive coverage.

[2] If you were enrolled for Dependent Life for your spouse/domestic partner in amount exceeding $250,000 prior to January 1, 2014, you were grandfathered into an amount that is no longer available for new elections. That amount is frozen and cannot be increased. If you reduce coverage to $250,000 or less in the future, your will no longer have access to coverage in amounts above $250,000.

The Plan also offers Accidental Death and Dismemberment insurance for your spouse/ABR Partner/ABR Health and/or Life that you may purchase in amounts from $10,000 to a maximum of the lesser of your total Basic and Supplemental Life benefits or $500,000, in $10,000 increments.

This coverage is available to your spouse or your Adult Benefits Recipient referred to in other parts of this document as your ABR.

Note: Your elections for spouse/ABR may be subject to a Statement of Health. Please refer to the **Evidence of Insurability/Statement of Health** section for more information.

Supplemental Spouse AD&D Coverage

The Plan offers Spouse Accidental Death and Dismemberment insurance for your spouse/ABR. You may purchase coverage in amounts from $10,000 to a maximum of $500,000, or the lesser of your total Basic plus Supplemental Life plus AD&D benefits, in $10,000 increments up to the plan maximum.

Child(ren) Insurance

Supplemental Child Life Coverage

The following coverage options are available to eligible child(ren):

- $20,000 is available per eligible child

Evidence of Insurability is not required for coverage for your dependent children.

Supplemental Child AD&D Coverage

The following coverage options are available to eligible child(ren):

- $20,000 is available per eligible child

Evidence of Insurability is not required for coverage for your dependent children.

If you and your spouse/ABR are both employed by Providence, or one of its ***affiliates***, you may both cover your dependent child for Dependent Life and Dependent AD&D Insurance.

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials

Accident
An unforeseen and unavoidable event resulting in an ***injury.***

Affiliate
Another health care entity affiliated with Providence whose benefits are administered by Providence St. Joseph Health.

Annual base pay earnings
Your life insurance is based upon your annual base pay. This is your current base rate of pay, as reflected in the payroll system (and if applicable, shift differentials and premium pay) as determined by Providence. It does not include income from commissions, bonuses, overtime pay, or any other extra compensation or income received from sources other than Providence.

For providers. The amount of your life insurance is based on the greater of a) the above definition, including any medical directorship pay you are eligible to receive or b) if you have been employed in your position for 12 consecutive months or more, your total earnings for a rolling twelve-month period. It includes all pay resulting from the performance of duties for Providence, including productivity pay and any medical directorship pay. It does not include signing bonuses, educational costs, licensure costs and similar items.

Beneficiary
The person(s) or other entity you designate to receive your life insurance, Accidental Death and Dismemberment (AD&D) insurance benefits if you die.

Certificate
A written statement prepared by the insurance carrier, which may include attachments. It tells you:

- The coverage for which you may be entitled;
- To whom the carrier will make a payment; and
- The limitations, exclusions and requirements that apply within a plan.

Hemiplegia
Total or partial paralysis of one side of the body.

HR Service Portal
Electronic resource for benefits information available at **hrforcaregivers.org**. Health and Welfare benefit elections can be entered by selecting the *Benefits – enroll, review or update (BenefitConnect)* link on the homepage under **External Links**. Access to the Benefits Service Center for questions is also available by navigating to the **Request HR Help > Benefits > Benefits Questions**. Other HR tools and resource materials are available on the portal.

Imputed income
The value of your basic life insurance coverage that is subject to tax, based on your age and amount of coverage. Your employer is required to calculate your imputed income for basic employee life insurance coverage over $50,000 using an IRS rate table. The value of supplemental life insurance coverage is not subject to imputed income because premiums are fully paid on an after-tax basis by the employee. Any amounts subject to imputed income will be shown on your annual W-2 statement.

Injury
Your loss or dismemberment results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. See the certificate for further information.

Limb
An arm or leg.

Loss
- For Accidental Death and Dismemberment (AD&D) coverage, loss means:
- For a hand or foot, complete separation or dismemberment through or above the wrist or ankle joint
- For an eye, total and irrecoverable loss of sight
- For speech, complete inability to communicate audibly in any degree
- For hearing, a loss that cannot be corrected by any hearing aid or device
- For a thumb and index finger, complete separation or dismemberment of both through or above the joint closest to the wrist

Paralysis
Loss of use, without severance of a limb. This loss must be determined by a physician to be complete and not reversible.

Paraplegia
Paralysis of the lower half of the body.

Plan Year
The fiscal year beginning January 1 and ending December 31.

Quadriplegia
Paralysis of all four limbs.

Severance
In the context of this chapter, complete separation and dismemberment of the limb from the body.

Long-Term Disability

Insurance Certificate

Long-Term Disability benefits are fully insured plans administered by New York Life Group Benefit Solutions (NYL), previously known as Cigna. As such, the insurance *certificate* governs the terms of coverage. You may access the *HR Service Portal* for a copy containing additional details about your coverage.

Overview

This long-term disability plan provides financial protection for you by paying a portion of your income while you are ***disabled***. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive partial disability payments even if you work while disabled.

Monthly payments begin after a benefits waiting period, also referred to as an ***elimination period***. Monthly payments continue until you reach your normal ***Social Security retirement age*** or when the maximum benefit period has been reached, whichever is later. (Please review the **How Long Benefits Last** section for more information.) You must continue to meet the Plan's disability requirements to continue receiving benefits, as described in the **How Disability Is Defined** section.

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this.***

Eligible employees are automatically enrolled for a basic level of long-term disability coverage as described in the table below. Optional coverage is available for some groups.

Eligible Employees	Coverage	Elimination Period (Waiting Period)	Buy-Up Plans
Providence (PH&S) Staff*	60% of monthly earnings, up to $10,000 per month	180 days	Buy-up Option A or B
PH&S Hood River Memorial Hospital	N/A	See Buy-Up Options for Hood River	Buy-Up Option 1, 2, 3, 4**
PH&S Holy Family Hospital	66 2/3% of monthly earnings, up to $10,000 per month	180 days	Buy-Up Option B
PH&S Leaders (employees earning $200,000 or more per year)	60% of monthly earnings, up to $15,000 per month	180 days	N/A

Eligible Employees	Coverage	Elimination Period (Waiting Period)	Buy-Up Plans
PH&S Physicians, Residents and Advanced Practice Practitioners	60% of monthly earnings, up to $15,000 per month	180 days	N/A
PH&S Executives (PL 490)	50% of monthly earnings, up to $25,000 per month.	180 days	N/A

Providence employees may also purchase buy-up coverage with a higher level of income replacement and/or a shorter ***elimination period***, as shown in the table below. Buy-up coverage integrates the core benefit provided by Providence with an option you pay for.

Buy-Up Options, as indicated on Basic Long-Term Disability Coverage Table		
Buy-Up Option	Coverage	Elimination Period
Option A	66.67% of monthly earnings, up to $10,000 per month	180 days
Option B	60% of monthly earnings, up to $10,000 per month	90 days
Buy-Up Options for Hood River**		
Buy-Up Option 1	50% of monthly earnings, up to $10,000 per month Note: Maximum 60-month benefit period	180 days
Buy-Up Option 2	60% of monthly earnings, up to $10,000 per month	180 days
Buy-Up Option 3	60% of monthly earnings, up to $10,000 per month	90 days
Buy-Up Option 4	66.67% of monthly earnings up to $10,000 per month	180 days

*Some buy-up options are not available, as certain locations have not implemented the paid time-away program; as a result, there is an Option B buy-up available only to caregivers in groups that have not implemented the standard paid-time away program. Check the ***HR Service Portal*** to determine the options available to you. ** Hood River Memorial Hospital offers four coverage options (see Buy-Up options for Hood River table above)

For more information please refer to the **How Benefits Are Calculated** section.

Review Your Coverage

To review your basic coverage, log on to the ***HR Service Portal***. If eligible, your long-term disability buy-up options and costs are displayed in the portal during Open Enrollment or when you first become benefits eligible. The amount of premium reflected is your per-pay-period cost of coverage for the Plan Year.

Active Employment Requirement

If you are not ***actively at work*** on the date long-term disability insurance would otherwise be effective, it will take effect on the date you return to ***active service***. This requirement also applies to increases you make to any existing coverage amounts.

You are actively employed when you are performing the material and substantial duties of your regular occupation and receiving pay from Providence, as your employer, on a regular basis. You must be working the minimum number of hours to be eligible for the Plan.

Your worksite must be either one of Providence's usual places of business; an alternative worksite at Providence, including your home; or at a location to which Providence business requires you to travel. A scheduled holiday or vacation is considered active employment. An employee is in active service on a day which is not a Providence-scheduled work day, if you were in active service on the preceding scheduled work day.

When Benefits Begin

Payments begin after the end of the ***elimination period*** (benefit waiting period). The elimination period is generally the first 90 or 180 days of continuous disability, depending on your Buy-Up option, if any. The first monthly benefit will begin one month after the date benefits begin to accrue. Subsequent payments will continue thereafter as long as you qualify under the terms of the Plan.

If, during the elimination period, your disability stops and then begins again within 30 days due to the same or related ***illness*** or accidental injury, you will not have to restart the elimination period. However, the days you are not disabled will not count toward your elimination period. During any period for which you are eligible for LTD, a ***premium waiver*** is applied to your continuing coverage.

Temporary Recovery (Successive Periods of Disability)

If you have been receiving disability payments, temporarily recover from your disability, and then become disabled again from the same cause, you do not have to serve a new ***elimination period*** as long as you remained continuously insured under the Plan and:

- The disability results from the same or related causes as a prior disability for which monthly benefits were payable, and
- After receiving disability benefits, you return to work in your regular occupation or a qualified alternative for less than six consecutive months and
- You earn less than the percentage of indexed earnings that would still qualify you to meet the definition of disability during at least one month.

Your recurrent disability will be subject to the same terms of the Plan as your prior claim. If you also have long-term disability coverage through another employer when your disability recurs, you will not be eligible for payments under this Plan.

Note: You must serve a new *elimination period* if your new disability results from unrelated causes.

How Long Benefits Last

If you become disabled, benefits are payable until the date you are no longer disabled as defined by the Plan, your normal ***Social Security retirement age*** or the time frame referenced below, whichever is later.

Age at Disability	Maximum Benefit Period
Under age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Survivor Benefits

A survivor benefit will be paid if you die while you are receiving disability benefits. The survivor benefit equals three times your gross monthly disability payment (the amount you received for the calendar month immediately preceding your death) provided you were entitled to receive payments under the Plan.

Benefits will be paid to your spouse/domestic partner, if alive. If there is no spouse/domestic partner, benefits will be paid in equal shares to your surviving children. If there are neither spouse/domestic partner nor children, benefits will be paid to your estate.

Spouse/ABR partner as used in the paragraph above means your lawful spouse or qualifying same or opposite gender domestic partner.

How Disability Is Defined

To receive benefits under this Plan, you must:

- Satisfy the ***elimination period***
- Be disabled as a result of a covered injury or ***illness***
- Be under the ***appropriate care*** of a licensed, practicing ***physician*** who is qualified to treat your disability
- Provide satisfactory ***proof*** of your disability.

Definition of Disability	
Staff	**Providers, Leaders and Executives**
During the ***elimination period*** and the next 24 months of ***illness*** or accidental injury, you are unable to perform the material duties of your regular occupation and you are unable to earn more than 80% of your ***pre- disability earnings*** at your own occupation from any employer in your locality. And after such period, you are unable to perform the material duties of any occupation and earn more than 60% of your pre-disability earnings from any employer in your locality at any gainful occupation for which you are reasonably qualified, taking into account your training, education and experience.	During the ***elimination*** period and after, you are unable to earn more than 80% of your ***pre-disability*** earnings at your own occupation.

NYL may require that you to be examined by a ***physician***, other medical practitioner and/or vocational expert of their choice. NYL will pay for this examination and can require an examination as often as it is reasonable to do so. NYL may also require you to be interviewed by an authorized NYL representative.

How Benefits Are Calculated

If you become disabled due to a covered injury or ***illness***, you will receive a total monthly income from all sources that is at least equal to the eligible percentage (60% or 66 2/3%) of your ***covered earnings*** at the time of disability.

Your monthly benefit is comprised of a percentage of your monthly ***covered earnings*** that has either been assigned to you or selected by you. Log on to the ***HR Service Portal*** to see your specific benefit or obtain a copy of the Long-Term Disability Certificate.

The minimum monthly benefit payment is the greater of $100 or 10% of your gross disability payment, regardless of income you receive from other sources while disabled. Maximum payments are provided in the table below.

Maximum Monthly Payment			
Staff	Leaders	Providers	Executives
$10,000	$15,000	$15,000	$25,000

Your long-term disability benefit will be indexed if you work while you are disabled, as described in the **Indexed Earnings** section below. If you receive disability benefits from other sources, your long-term disability benefit from this plan will be reduced, as described in the **Other Income Sources** section.

Note: If an overpayment has been made, the benefit may be reduced to recover the overpayment, or you may be required to repay any overpayments to New York Life.

Covered Earnings

Staff, Leaders and Executives	Providers (Physicians, Residents and APPs)
Your wages or salary as reported by Providence for worked performed in effect just prior to the date your disability begins. This includes medical directorship pay, but does not include pay for bonuses, commissions, overtime or any other extra pay.	The greater of the following: a) Your annual current base rate of hourly pay, just prior to the date your disability begins. b) If you have been employed in your position for 12 consecutive months or more, your total earnings paid during the 12-month period prior to your last day of active work before your disability begins. It includes all pay resulting from the performance of duties for Providence, including productivity pay and any medical directorship pay. It does not include signing bonuses, educational costs, licensure costs and similar items.

Any increase in ***covered earnings*** will not be effective during a period of continuous disability.

Indexed Earnings (Cost of Living Adjustment)

For the first 12 months monthly benefits are payable, your indexed earnings are equal to your ***covered earnings***. After 12 monthly benefits are payable, your indexed earnings are your covered earnings plus an increase applied on each anniversary of the date monthly benefits became payable.

The amount of each increase will be the lesser of:

- 10% of your indexed earnings during your preceding year of disability, or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year. The Consumer Price Index is published by the U.S. Department of Labor. NYL reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

The increase will become effective on January 1 and will be payable for as long as disability benefits are payable to you, up to ten years. This is not applied to the minimum or maximum benefit and it is not applied to the formula used to determine your work incentive benefit.

Other Income Sources

- If you receive disability benefits from sources other than this Plan, your long-term disability benefits from this Plan will be reduced by the amount of other income sources. Other income benefits include:
- Any amounts received (or assumed to be received*) by you or your dependents under:
- The Canada and Quebec Pension Plans;
- The Railroad Retirement Act;
- Any local, state, provincial or federal government disability or retirement plan or law payable for Injury or illness provided as a result of employment with the Employer;
- Any work loss provision in mandatory "No-Fault" auto insurance.
- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.
- Any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 40l (k) plan.
- Any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for disability and contains the same or similar provision for reduction because of other insurance, we will pay for our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
- Any amounts received (or assumed to be received) by you or your dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
- Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

*Dependents include any person who receives (or is assumed to receive) benefits under any applicable law because of your entitlement to benefits.

Benefits will not be reduced by your Social Security income if your disability begins after age 65, and you were already receiving Social Security retirement payments.

Exceptions to Other Income Benefits

Your benefits will not be reduced by payments from:

- Cost of living adjustments that are paid under any of the above sources of Other Income.
- Reasonable attorney fees included in any award or settlement if the attorney fees are incurred because of your successful pursuit of Social Security disability benefits
- Mortgage disability insurance benefits
- Veteran’s benefits
- Individual disability income insurance policies
- Benefits received from an accelerated death benefit payment
- Amounts rolled over to a tax-qualified plan unless subsequently received by you while you are receiving benefit payments
- Vacation pay or PTO earned prior to your disability
- Severance pay

Return-to-Work Incentive

To encourage you to return to work as soon as medically possible, the Plan offers return-to-work incentives. You may continue to receive benefits if you return to work but continue to meet the definition of disability.

This incentive will not be reduced by the amount you earn from working, but the total monthly benefit plus any income you earn from working, and deductible income may not exceed 100% of your pre-disability earnings as calculated in the definition of disability. In addition, the minimum monthly benefit will not apply.

Limit on Work Incentive

After 24 months of disability benefit payments, your disability benefits will be reduced by 50% of the amount you earn from working while disabled.

Rehabilitation during a Period of Disability

If you are disabled, you may be eligible to participate in a ***rehabilitation plan*** or may be participating in a program that you desire to have approved by NYL as a rehabilitation plan. If you desire to participate in rehabilitation efforts or to have your program approved by NYL as a rehabilitation plan, you may request approval from NYL. NYL retains the sole discretion to approve your participation in a rehabilitative plan and to approve a program as a rehabilitative plan.

If, while you are disabled, NYL identifies that you are a suitable candidate for rehabilitation, you may participate in a rehabilitation plan. The terms and conditions of the rehabilitation plan must be mutually agreed upon by you and NYL.

The rehabilitation plan may, at NYL discretion, allow for payment of your medical expenses, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

Filing Claims

To file a claim, contact NYL. ***Proof*** of loss must be filed with NYL no later than 90 days after the end of the ***elimination period*** for which the claim is filed.

Limitations

Pre-existing Conditions Limitation

Benefits will not be paid for any period of ***disability*** caused by, contributed to, or resulting from a ***pre-existing condition*** until you have been continuously insured and ***actively at work*** for 12 months.

A pre-existing condition is an injury or ***illness***:

- For which you received medical treatment, consultation, care, or services; took prescribed medications or had medications prescribed; or had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment during the three months just prior to your effective date of coverage.
- That begins in the first 12 months after your effective date of coverage. If you increase your coverage level, and you become disabled within 12 months of that increase for a condition that results from a pre-existing condition, your benefits will be paid based on your prior coverage level.

Alcohol, Drug or Substance Abuse or Addiction Limitation

There is a maximum benefit and frequency limitation for your disability due to alcohol, drug, or substance abuse or addiction. Up to 24 months of the disability benefit is paid for such disabilities.

Mental or Nervous Disorders or Diseases

Up to 24 months of the disability benefit is paid for most mental or nervous disorders or diseases. You may be eligible to receive disability benefits on a limited basis for a disability caused by, or contributed to by, any one of more of the following conditions.

- Anxiety disorders
- Depressive disorders
- Mental illness
- Delusional (paranoid) disorders
- Eating disorders
- Somatoform disorders (psychosomatic illness)

If you are disabled due to one or more of the preceding disorders, your lifetime benefit is the lesser of 24 months or the maximum benefit period. Your disability benefit is limited, except for a mental or nervous disorder or disease as follows:

- Schizophrenia
- Dementia
- Organic brain disease

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the ***appropriate care*** of any of the conditions listed above.

Exclusions

Disabilities caused by, contributed to, or resulting from the following are not covered by the Plan:

- Attempted suicide or intentionally self-inflicted injuries while sane or insane
- Active participation in a riot
- Commission of, or attempt to commit or take part in a felony
- War, whether declared or undeclared
- The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or ***illness*** otherwise covered by the policy.

In addition, disability benefits are not available for any period during which you are incarcerated in a penal or corrections institution.

Termination of Disability Benefits

Benefits will end when the first of these occurs:

- The date you earn, from any occupation, more than the percentage of indexed earnings set forth in the definition of disability, applicable to you at that time.
- The date you are determined not to be disabled under the terms of the Plan
- The end of the maximum benefit period

- The date you die
- The date you are no longer receiving ***appropriate care.***
- The date you fail to cooperate with NYL in the administration of the claim. Such cooperation includes, but is not limited to, providing any information needed to determine whether benefits are payable or the actual benefit due.

Conversion

If your long-term disability insurance is terminated due to your employment status changing (such as going from a benefits-eligible to non-benefits-eligible position) or your employment ending, and you have been insured for 12 months under the policy, you will receive information from NYL, after your active coverage has ended, to allow you to continue coverage through conversion. Keep in mind that the coverage in place at the time of your disability covers your current disability, as applicable. You must submit your request for conversion within 62 days of the day active coverage ended.

Conversion insurance is not available if any of the following conditions apply:

- You are retired or age 70 or older;
- You are not actively at work due to a disability;
- You are no longer in a benefits-eligible class
- The policy is canceled.

Voluntary Individual Disability Insurance

Executives and providers (including providers in medical director role) earning $100,000 or more and others earning $200,000 or more may enroll in a voluntary individual disability insurance (IDI) policy to supplement the employer-provided disability plan. IDI can replace up to 75% of your base pay, up to an additional $10,000 per month.

Enrollment in IDI takes place once each year and offered one time only. You will receive enrollment information, if eligible. This policy is governed by the terms and provisions as stated in your individual insurance certificate issued by UNUM.

Please refer to your certificate of insurance or contact UNUM at 1-800-ASK-UNUM or **askunum@unum.com** with questions."

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials.

Actively at work or active service

Means that you are performing all of the usual and customary duties of your job on a ***full-time*** or ***part- time*** basis. This must be done at:

- A Providence place of business
- An alternate place approved by Providence
- A place to which Providence business requires you to travel

You will be deemed to be actively at work during weekends or Providence-approved vacations, holidays or business closures if you were actively at work on the last scheduled work day preceding such time off.

Appropriate care and treatment

Means you

- Have received treatment, care and advice from a physician who is qualified and experienced in the diagnosis and treatment of the conditions causing the disability. If the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the physician is a practitioner in that specialty.
- Continue to receive such treatment, care or advice as often as is required for treatment of the conditions causing the disability.
- Adhere to the treatment plan prescribed by the physician, including the taking of medication.
- Receive care given by a physician whose medical training and clinical specialty are appropriate for treating your disability
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies
- Consistent with a physician's diagnosis of your disability
- Intended to maximize your medical and functional improvement

Consumer Price Index

The CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the CPI-W is discontinued or replaced, NYL reserves the right to substitute any other similar measure.

Covered Earnings

Covered earnings are your base pay excluding overtime or other pay base rate of pay (and if applicable, shift differentials and premium pay), as reported for work performed for your employer as in effect just prior to the date your disability begins. It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation.

Elimination period

The period of your disability during which NYL does not pay benefits. The elimination period begins on the day you become disabled and continues for the period shown in the schedule of benefits.

Full-time

Means the number of hours set by Providence as a regular work day for employees in your eligibility class that allow for the extension of benefits.

HR Service Portal
Electronic resource for benefits information available at **hrforcaregivers.org**. Health and Welfare benefit elections can be entered by selecting the *Benefits – enroll, review or update (BenefitConnect)* link on the homepage under **External Links**. Access to the Benefits Service Center for questions is also available by navigating to the **Request HR Help > Benefits > Benefits Questions**. Other HR tools and resource materials are available on the portal.

Illness
A physical or mental illness.

Part-time
See full-time.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an employee that is appropriate for the condition and locality.

The treating physician may not be:
- You
- Your spouse or
- Any member of your immediate family including your and/or your spouse's:
  - Parents
  - Children (natural, step or adopted)
  - Siblings
  - Spouses of any of the above-listed relatives
  - A person living in your household

Pre-disability earnings
Total covered earnings, as defined by Providence, before taxes. See Covered Earnings.

Proof
Written evidence satisfactory to NYL that a person has satisfied the conditions and requirements for any benefit described in this certificate.

Rehabilitation plan
A written plan that has been approved by NYL for the purpose of helping you return to work. It may include, but is not limited to, your participation in one or more of the following activities:
- Rehabilitation, under which NYL may provide, arrange, or authorize education, vocational or physical rehabilitation or other appropriate services
- Work, which may include modified work and work on a part-time basis

Social Security retirement age
As defined by the federal Social Security Administration on the date your disability starts.

Health Care Flexible Spending Account

Providence offers employees the opportunity to save money by paying eligible health care expenses on a pre-tax basis through the Health Care Flexible Spending Account (Health Care FSA or HC FSA). You may pay providers directly from the account or be reimbursed.

You elect an amount you want to set aside for the year, then each pay period Providence deducts the amount you chose from your paycheck on a pre-tax basis. This money funds your Health Care FSA, which you can use to pay for eligible medical, dental and/or vision expenses.

To be eligible, the expenses must meet certain IRS criteria, noted below. In addition, the expenses must be incurred during the ***Plan Year*** (January 1 to December 31). Expenses are not eligible if they are fully covered by the medical, dental, and vision plans.

There are special rules if you are enrolled in the HSA medical plan.

See “If You Are Enrolled in the HSA Medical Plan” on next page.

The money you contribute to your Health Care FSA is deducted from your paycheck before federal income, Social Security or Medicare taxes. This means you save on your taxes. Your federal tax status affects how much you will save in federal taxes. For additional information about tax implications for flexible spending accounts, please consult your tax advisor.

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this***.

How Much Can I Elect?

You may elect from $120 to $2,750 per ***Plan Year***; the limit is subject to annual adjustments, as permitted by federal regulations. If you submit your elections on or after November 1 of the current year, you are not eligible to make Health Care FSA elections for the current year. This amount will never be greater than your pay.

It’s important to plan carefully, as you generally cannot change your election during the ***Plan Year.*** You may change your elected amount mid-year in certain situations if you have a qualifying event. Please see the **Qualifying Events** section of the **Eligibility and Enrollment** chapter for more information. At the end of the Plan Year, if funds remain in the account, you are permitted to carry over up to $550 in unused funds to the following Plan Year. You are not required to re-enroll in the Health Care FSA for the following year in order to access unused funds of up to $550. Any funds in excess of $550 are forfeited at the end of the Plan Year. (Please see **How Do I Use My Account**).

Note: Funds are available on the first day of your FSA plan year, which is generally January 1 unless you enroll later in the year. Eligible rolled over funds from the prior *Plan Year* are available for your use on or after April 30.

Note: You must make an annual election each year during Open Enrollment; your election amount does not carry forward from year to year. If you are a newly hired or newly benefits-eligible employee, you may not enroll in a spending account after November 1 of the calendar year to allow for year-end processing.

The Plan Administrator may, at any time, require an amendment to your elections for a Plan Year if the Plan Administrator determines it is necessary to satisfy the Internal Revenue Code's non-discrimination rules.

If You Are Enrolled in the HSA Medical Plan

If you enroll in the HSA medical plan, and you also elect a Flexible Spending Account, IRS rules do not allow you to have the same type of FSA arrangement (general purpose) that you would have if you were enrolled in one of the other medical plan options offered. If you are an enrollee in the HSA medical plan, the Health Care FSA becomes a ***Limited Purpose Flexible Spending Account (LPFSA)***.

Expenses reimbursed by a LPFSA are restricted until you reach your medical plan's ***deductible***. Here's how it works:

Before you meet your medical plan deductible, your LPFSA funds are available only for certain expenses, including:

- Dental care and orthodontia, such as fillings, X-rays, braces, caps and mouth guards
- Vision care, including eyeglasses, contact lenses, solutions and supplies, and LASIK eye surgery

Note: If you have incurred medical expenses that are not covered by the HSA medical plan, you may not use your LPFSA to reimburse those expenses unless your medical plan deductible has been met. You may, however, use your HC FSA account for those expenses.

After you meet your ***deductible***:

- You will get reimbursed for all Health Care FSA qualified health care expenses, except your deductible, in addition to any eligible dental or vision expenses

In all other respects, the LPFSA functions just as a Health Care Flexible Spending Account.

If you elected the Providence HSA medical option, but are, or become, ineligible to receive contributions to a Health Savings Account (HSA) your account will no longer be subject to the restrictions of a LPFSA.

Who Administers the Benefits

The Plan has contracted with HealthEquity as the Claims Administrator to handle day-to-day Health Care FSA administration. The Claims Administrator answers claim questions, makes claim decisions, reimburses claims, processes claim appeals, and maintains account balances.

Statements

You can check your account balance online by logging on to the ***HR Service Portal***, **healthequity.com** or by calling the number on the back of your debit card.

What Are Eligible Expenses?

You may use your Health Care FSA to pay for eligible out-of-pocket expenses for the following individuals, regardless of whether they are enrolled for health coverage through your employer:

- Yourself
- Your spouse

- Your ***dependent*** child through the end of the year in which the child turns age 26
- Any other federal tax dependents

Note: The expenses of your Adult Benefits Recipient (ABR) and/or his or her child(ren) are typically not eligible for coverage in the Health Care FSA, unless the person is also a federal tax dependent.

The type of Health Care FSA you are eligible for is determined by the type of medical plan you are enrolled in:

- If you waive medical or enroll in another medical plan other than the HSA medical plan, you will be eligible for the Health Care FSA. You can use your HC FSA account to pay for qualified medical, pharmacy, dental or vision expenses
- If you are enrolled in the HSA medical plan, you will be eligible for the Limited Purpose Health Care FSA. You can use your LPFSA account to pay only for out-of-pocket vision and dental expenses, or post-deductible medical and prescription drug expenses

Qualifying medical care expenses are defined by the IRS as amounts "paid for the diagnosis, cure, medication, treatment, or prevention of disease, or for transportation primarily for and essential to medical care." All expenses must be qualified expenses as defined in Section 213(d) of the Internal Revenue Code. You can obtain a complete list of eligible expenses on the HealthEquity website, **healthequity.com.**

Some examples of items that may qualify for reimbursement are:

- Any ***deductibles***, ***copayments*** and ***coinsurance*** you may have to pay under your elected medical, dental, or vision option
- Any health charges in excess of medical, dental and vision plan limits, for example:
  - Additional cost to you if a second surgical opinion or hospital preadmission certification is not obtained when required
  - Dental expenses in excess of plan payments (such as orthodontia in excess of $2,000)
  - Vision expenses in excess of VSP payments
- Any IRS-eligible health care charges not covered by the medical, dental and vision plans and not specifically excluded by this plan (see the **Exclusions** section)
- Prescribed medicines and drugs; a prescribed drug is one that requires a prescription by a doctor for its use by an individual. You can also include the amount you pay for insulin. Except for insulin, over-the-counter drugs are not reimbursable under the Plan unless there is a prescription or letter of medical necessity from your provider. Note: the requirements are subject to change based on temporary federal legislative changes. Contact HealthEquity with questions regarding reimbursable expenses.

The expenses may be incurred for services provided to you, your spouse, any person who would qualify as your ***dependent*** under federal income tax rules (even if they are not covered under the medical, dental, or vision option you select) and your child up to age 26.

Orthodontia Claims

Orthodontia work is often paid in full up front by the patient. If you pay for orthodontic services in advance, you may submit the prepaid out-of-pocket amount for reimbursement from a Health Care FSA in the plan year in which the payment was made, whether or not the services are performed in the same ***Plan Year*** as your payment. No reimbursement is available if actual payment is not made.

If you pay for orthodontia care on a payment schedule, the payment date will serve as the treatment date for determining reimbursement from an account during the year. Therefore, only the amount to cover one calendar year of out-of-pocket payments should be put into your Health Care FSA.

Exclusions

The Plan does exclude some expenses for reimbursement which are consistent with the Ethical and Religious Directives for Catholic Health Care Services. Some of these exclusions may be IRS-eligible expenses. Expenses that do not qualify for reimbursement through the Health Care FSA include:

- Charges for services obtained before the effective date of your contributions to the account for the Plan Year
- Charges for services obtained after the discontinuance of contributions to the account for the Plan Year, other than the rollover provision
- Health care insurance premiums
- Payments to domestic help, companion, babysitter, chauffeur, etc., who primarily renders services of a nonmedical nature
- Nursemaids or practical nurses who render general care for healthy infants
- Cosmetic surgery, unless medically necessary and allowed under IRS regulations
- Teeth Whitening
- Tattoos and ear piercing
- Religious cult deprogramming
- Fees for exercise, athletic or health club memberships
- Physical treatments unrelated to a specific health problem (for example, massage for general well-being)
- Payments for Church of Scientology auditing and processing
- Marriage counseling provided by clergy members
- Weight reduction programs for general well-being and appearance
- Any illegal treatment
- Psychoanalysis undertaken to satisfy a student's curriculum requirement
- Cost of items for general health or appearance, such as vitamins, dietary supplements, toiletries, cosmetics and sundry items (for example, soap, toothbrushes)
- Cost of illegal drugs
- Cost of nonprescription drugs, except as defined under **What Are Eligible Expenses**
- Maternity clothes
- Diaper service
- Distilled water purchased to avoid drinking fluoridated city water supply
- Vacuum cleaner purchased by individual with dust allergy
- Mechanical exercise device not specifically prescribed by doctor
- Insurance against loss of income; loss of life, limb, or sight
- Contributions to state disability funds
- Over-the-counter drugs and medicines without a physician's prescription; unless otherwise permitted by federal law
- For the Limited Purpose Health Care FSA, pre-deductible medical and prescription drug expenses
- Abortion or sterilization
- Drugs which act as, or which under the Ethical and Religious Directives for Catholic Health Care Services Part 4 (fifth edition) are considered to act as, abortifacients
- Expenses due to infertility treatments

How Do I Use My Account?

You have until March 31 of the following year to submit all documentation to seek reimbursement of expenses incurred during the Plan Year. If you have money in your account, you may have the following options to pay for eligible expenses using your Health Care FSA:

- Participants may pay for eligible expenses directly from their flexible spending account using online tools at **healthequity.com**
- Pay with your HealthEquity debit card at the time of service. **Note: After the end of the Plan Year, you must submit claims for expenses incurred in the prior Plan Year, as your debit card will apply the expense only to your current year account.**
- Pay with cash, check or credit card, and then seek reimbursement online, by fax or by mail

The annualized amount of your election is available at the beginning of the Plan Year, or as of your effective date if you are newly eligible. The available balance will be reduced by any claims paid to date.

Rolling Over up to $550

If you have a balance at the end of the Plan Year, you are eligible to roll over up to $550 of unspent FSA dollars. Any amounts over $550 are forfeited, if not claimed with expenses incurred in the year in which contributions were made. Eligible rolled over funds will not be available until on or after April 30.

An eligible rollover amount of less than $10.00 at the end of the Plan Year will be forfeited with no enrollment in the following year.

Note: if you change medical plans in the subsequent year, your rollover funds will be placed in a compatible account with your new medical plan.

Paying Directly for Expenses from Your Medical Plan

If you are enrolled in a Providence medical plan, eligible medical expenses may be paid directly from your flexible spending account. You can choose from the following options:

- Online processing where you determine which claims are to be paid to providers
- Online processing where you reimburse yourself

Paying with the Debit Card

You will receive a HC FSA debit card and each individual participant will receive a debit card upon request which may be used at eligible health care merchants and providers that accept the VISA card. Using the debit card eliminates the need for you to pay for expenses with your own funds, submit a claim, and wait for a reimbursement. Simply present your debit card to pay for your eligible expenses. The provider will be paid directly from your account, up to your available balance.

When you use your debit card, you are agreeing to the terms of the cardholder agreement. By signing the receipt and authorizing the transaction, you agree:

- To use the card only at authorized medical, dental, and vision providers
- To use the card for eligible medical, dental, and vision expenses as allowed by IRS regulations and eligible under the terms of the plan document
- That the transactions have not and will not be reimbursed under any other insurance plan or health care reimbursement plan

HealthEquity may request additional documentation in order to substantiate a debit card expense. You will be required to repay funds that were either not substantiated, or were deemed ineligible under the terms of the Plan.

Paying for Expenses and Seeking Reimbursement

If you pay for eligible expenses without using the debit card (i.e., via cash, check, or credit card), you may submit a claim form with a detailed receipt to request reimbursement or you may submit a claim online and upload your receipt/documentation. HealthEquity, the Claims Administrator, will generally pay your claim within a few business days and will contact you if any additional information is required. The amount of your claim will be deducted from your available balance from the account you designate on the form, reducing the amount available for reimbursement or payment directly via the website or your debit card.

Reimbursement forms are available on the HealthEquity website below. You may also fax your claims to the ***Claims Administrator***, or submit them online:

HealthEquity Inc.
15 Scenic Pointe Dr. Ste. 100
Draper, UT 84020
Toll-free: 877-372-6667

Fax: 801-999-7829
http://www.healthequity.com

Documenting Your Claims

The IRS requires you to obtain a receipt for every debit card transaction and, if necessary, submit the receipt to substantiate the expense. A receipt is also required when submitting a claim form. Ask the provider for a detailed receipt at the time of transaction and save it. If a receipt is required, the ***Claims Administrator*** will contact you. If you are unable or unwilling to provide a receipt when requested, the IRS regulations require the Claims Administrator to deem the transaction ineligible and the amount of the transaction must be repaid to the Plan.

Note: If you do not repay the administrator for ineligible claims, the amount of the transaction may be deducted from your pay on an after-tax basis.

Termination of Coverage

If you terminate employment, or your status changes so that you are no longer eligible, you may continue to submit claims for services that were incurred through the date your participation in the account ends, until three months after the end of the ***Plan Year*** or until your balance is depleted, whichever comes first.

You will need to elect COBRA continuation of coverage for your Health Care FSA if you would like to contribute and be reimbursed for services that are incurred after your participation ends. Contributions to the Health Care FSA under COBRA are made on an after-tax basis.

For the time period during which you make COBRA after-tax contributions, you can submit claims for reimbursement on the same basis as similarly situated active employees. All claims for reimbursement must be submitted by March 31.

Note: If you do not elect COBRA continuation coverage for your Health Care FSA, IRS regulations do not allow you to contribute to or claim expenses incurred to your Health Care FSA after you terminate employment.

HEART Act of 2008

Under the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act of 2008), military reservists who are called to active duty for 180 or more days or for an indefinite period may receive a distribution of all or a portion of the unused funds in their Health Care FSA. “Unused funds” refers to the amount you contributed to the Health Care FSA as of the date you request a distribution, minus your claims for reimbursement for the ***Plan Year*** for expenses incurred up until and including the same date.

If you wish to take a distribution under the HEART Act of 2008, you must make the request so that the distribution is made during the period beginning on the date you are ordered or called into active duty and ending on the last day reimbursement from the Health Care FSA would otherwise be made for the Plan Year.

Your distribution request from the Health Care FSA will be processed within thirty (30) days of the date the request is received. Distributions from the Health Care FSA that are permitted under the HEART Act of 2008 will be subject to tax withholding. However, such distributions are not subject to tax penalties.

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials.

Claims Administrator
A third party administrator or insurer designated by the plan administrator or its delegate to review and process claims for benefits under the Plan.

Coinsurance
A cost-sharing requirement that requires a participant to pay a specific percentage of the cost for certain covered services.

Copayment
The fixed dollar amount you (or your family) pay to a provider for a covered service at the time care is provided.

Deductible
The amount you (or your family) must pay each **Plan Year** before the Plan will pay for covered services.

Dependent
Eligible dependents are your spouse and persons you can claim as a dependent on your federal tax return.

HR Service Portal
Electronic resource for benefits information available at **hrforcaregivers.org**. Health and Welfare benefit elections can be entered by selecting the *Benefits – enroll, review or update (BenefitConnect)* link on the homepage under **External Links**. Access to the Benefits Service Center for questions is also available by navigating to the **Request HR Help > Benefits > Benefits Questions**. Other HR tools and resource materials are available on the portal.

Plan Year
The twelve (12) month period beginning January 1 and ending December 31.

Dependent Care Flexible Spending Account

Overview

Providence offers employees the opportunity to save money by paying eligible child care or other dependent care expenses on a pre-tax basis through the Dependent Care Flexible Spending Account (DC FSA). If you are paying for child care or other dependent care services so that you or you and your spouse can work (or study as a full-time student), you can use the dependent care flexible spending account to pay for day-care costs in a tax-effective manner. You cannot use the dependent care flexible spending account when you are on a leave of absence. (Note: This account is not reimbursement of the health care expenses of your dependent – see the **Health Care Flexible Spending Account**.)

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this***.

Each pay period, Providence deducts the amount you choose from your paycheck on a pre-tax basis. This money funds your flexible spending account, which you can use to pay for eligible expenses.

To be eligible, the expenses must meet certain IRS criteria, noted below. In addition, the expenses must be incurred during the calendar year (January 1 to December 31) in which you are participating.

Taxes

The money you contribute to your dependent care flexible spending account is deducted from your paycheck before federal income, Social Security or Medicare taxes. This means you save on your taxes. Your federal tax status affects how much you will save in federal taxes.

If you choose to be reimbursed for day-care expenses from the dependent care flexible spending account, you cannot take advantage of federal or state child care and dependent care income tax credits for the same expenses. For some people, the tax credits are preferable to reimbursement; for others, reimbursement from the dependent care flexible spending account is best.

For additional information about tax implications for flexible spending accounts, please consult your tax advisor.

How Much Can I Elect?

Participation in the dependent care flexible spending account is optional. You may elect from $120 to $5,000 per ***Plan Year***, subject to the limitations described below.

- If you are single, you may contribute up to $5,000.
- If you are married and file a separate federal income tax return, you may contribute up to $2,500.

- If you are married and file a joint return, the maximum allowable contribution for your household is the lesser of your or your spouse's income (but not more than $5,000). For example, if you earn $25,000 and your spouse earns $4,000, you may not contribute more than $4,000 to your dependent care flexible spending account. If your spouse is a full-time student or incapable of self-care, your spouse's earned income is assumed to be at least $250 a month if you have one ***dependent*** or $500 a month if you have two or more dependents.

Your elected amount for the ***Plan Year*** ending December 31 is deducted in equal amounts from each paycheck (up to 26 per year if election is effective January 1). This amount will never be greater than your pay.

Note: You must make an annual election each year during Open Enrollment; your election amount does not carry forward from year to year.

Note: If you and your spouse both work for Providence, you are responsible for electing an amount that complies with the annual IRS limit of $5,000 for couples filing a joint return, or $2,500 per person if filing separately.

Can My Elections Be Changed?

The Plan Administrator may, at any time, require an amendment to your elections for a Plan Year if the Plan Administrator determines it is necessary to satisfy the Internal Revenue Code's non-discrimination rules.

It is important to plan carefully, as you generally cannot change your election during the ***Plan Year***, and any amount left over at the end of the Plan Year will be forfeited. You may change your elected amount mid-year if you have a qualifying event, including if your day-care costs increase or decrease significantly. Please see the **Qualifying Events** section of the **Eligibility and Enrollment** chapter for more information.

What Are Eligible Expenses?

You may use the dependent care flexible spending account for eligible dependent care expenses incurred while you are participating in the dependent care flexible spending account.

Eligible expenses include:

- Care at a licensed day-care facility
- Private sitter (excluding babysitting which allows you and/or your spouse to participate in social or recreational activities whether or not work related)
- Care at a child day-care center or adult care center; if the day-care center cares for more than six children, the center must comply with all state and local laws and charge a fee for providing care
- Cost of schooling (if your child is under the age of first grade and if the cost of schooling and the cost of care cannot be separated)
- A housekeeper, au pair, or nanny whose services include providing care for an eligible dependent
- In-home providers, as long as it is someone other than your spouse, a person you list as a dependent on your federal tax return or one of your children under the age of 19
- Babysitting services (work related)
- Day camp (work related)
- Practical nursing care for an incapacitated spouse or parent

Refer to IRS Publication #503 (Child and Dependent Day Care Expenses), available at your local IRS office, by calling 800-TAX-FORM (800-829-3676) or by visiting the IRS website at **irs.gov** for a complete list of eligible expenses. The Internal Revenue Code defines eligible and excluded expenses.

Note: You must provide the name, address, and taxpayer identification number (for example, Social Security number) of your day-care provider. This is not necessary if your provider is exempt from federal income taxes, such as a church group.

If Care Is Provided for a Child

Services will qualify for reimbursement from the dependent care flexible spending account if they are:

- Incurred to enable you or you and your spouse, if you are married, to be employed or study as a full-time student
- Incurred for a child under 13 years old and who is your ***dependent*** under federal tax rules
- Provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (for example, an older child)
- For the physical care of the child, not for education, meals, lessons such as sailing or photography, etc.

If the services are provided by a day-care facility that cares for six or more children at the same time, it must be a qualified day-care center and have a tax identification number (TIN).

If Care Is Provided for Another Dependent

The dependent care flexible spending account can also be used for a spouse or ***dependent*** who is incapable of self-care (for example, an invalid parent). The dependent must be claimed as such on your tax return. The dependent must regularly spend at least eight hours per day in your home. The same rules that apply to child care apply to the care of other dependents, except that the dependent need not be under age 13.

Exclusions and Limitations

Expenses which do not qualify for reimbursement through the dependent care flexible spending account include:

- Expenses for food and education unless they are provided by the nursery school or day-care center as part of its preschool care services
- Tuition, clothes, and entertainment
- Full-time care in a custodial or residential nursing home
- Overnight sleep-away camp
- Expenses for transportation between your home and the place where dependent day-care services are provided or to pick up a dependent day-care provider
- Expenses claimed on your federal tax return under the federal dependent care tax credit
- Dependent medical and health care expenses
- Services provided before you began participation in the dependent care flexible spending account or after your participation ended
- Expenses for dependents who do not meet the eligibility requirements
- Care provided by your spouse, a dependent or your child(ren) who are under age 19 at the end of the year
- Care provided by anyone you claim as a dependent on your federal income tax return
- Dependent day-care expenses you pay while you are not working or do not otherwise meet the eligibility requirements
- Day-care expenses incurred while the caregiver is on a leave of absence

How Do I Use My Account?

You pay your dependent care provider directly and then you request reimbursement from your dependent care flexible spending account. **You may only be reimbursed up to the amount you have contributed at the time of submission.**

To be reimbursed, you will need to submit a claim form, along with documentation of your payment to HealthEquity, our ***Claims Administrator***.

Claim forms are available on the HealthEquity website below. You may also check your balance and submit claims online. Alternatively, you may mail or fax your claims to HealthEquity at the address below.

HealthEquity Inc.
15 Scenic Pointe Dr. Ste. 100
Draper, UT 84020
Toll-free: 877-372-6667 Fax: 801-999-7829 **http://www.healthequity.com**

You may submit claims at any time during the year. However, your total reimbursements at any time during the year cannot exceed the amount you have contributed through payroll deductions at that time.

HealthEquity will generally pay your claim within a few business days, and they will contact you directly if they require any additional information.

Termination of Coverage

If you terminate employment and have a balance in your dependent care FSA, you may continue to submit claims until three months after the end of the Plan Year or until your balance is depleted, whichever comes first. You may only submit claims for services provided through the date that your employment ended; you are not able to continue participation in this benefit after termination. For example, Bob elected to participate in a dependent care flexible spending account. On June 1, he terminated employment with Providence Health & Services. He can no longer submit claims for any services incurred after June 1, but he may continue to submit claims for expenses incurred prior to that date; the Plan allows him to submit the eligible expenses through March 31 of the following year.

Note: IRS regulations do not allow you to contribute to or claim expenses incurred to your dependent care flexible spending account after you terminate employment.

Glossary

You may see definitions for these terms within the Summary Plan Description or in other benefits materials.

Claims Administrator
A third party administrator or insurer designated by the plan administrator or its delegate to review and process claims for benefits under the Plan.

Dependent
Eligible dependents mean your spouse and persons you can claim as dependents on your federal tax return.

Plan Year
The twelve (12) month period beginning January 1 and ending December 31.

Problem Resolution, ERISA and HIPAA Information

Eligibility and Enrollment Claims

Issues of whether you or your dependents are eligible to participate in, or obtain coverage under a benefit plan, or whether you or your dependents are enrolled for participation in, or covered under a benefit plan, are determined by the ***Plan Administrator*** or its designee. Employees who believe there was an administrative error, system error or other circumstance affecting their benefits elections may file an appeal. For this to be considered, you will need to log on to the ***HR Service Portal*** and open a case/ticket. In the ***HR Service Portal*** search bar, type "Benefits Appeal" and complete the requested information and then click the Submit button. The appeal must include sufficient details and supplemental documentation may be attached in the request. Appeals must be filed by the employee.

The ***Plan Administrator*** or its designee will review the request to determine if there is a compliant-basis for approval under the terms of the Plan and applicable regulations. You will receive a written response either via the work email address on file or U.S. mail at the home address on file with the ***Plan Administrator*** within 30 days from the date each appeal was received. Two levels of appeals are available for eligibility and enrollment claims.

Informal Member Problem Resolution Under the Medical Plans

Your Providence Health Plan (PHP) Customer Service Team is available to provide information and assistance at 800-878-4445. You may call them or set up an appointment with them to discuss your concern. If you have special needs, such as a hearing impairment, call their TTY (telephone device for the hearing impaired) number at 711. Please contact them so they may help you with whatever special needs you may have.

Note: If you have coverage through the DeltaCare USA DHMO Plan, please refer to your benefits booklet in the Appendix of this document, for information regarding appeal rights for that plan.

Plan Definitions

At the end of this chapter, you will find a **Glossary** that defines terms formatted ***like this***.

Filing and Processing of Claims

In most cases, network providers and hospitals submit claims for you, and there are no claim forms for you to complete. If you do receive a bill for services from your provider, you can access the necessary claim forms on the Providence Health Plan website though a link from the ***HR Service Portal.*** The forms give you the details of how a claim is filed.

Any bill you submit must contain:

- Provider name
- Provider tax ID information
- Specific dates of service
- Diagnosis codes (ICD-10 codes) or description of the symptoms or a diagnosis
- Specific procedure codes (CPT codes) or description of the medical service or procedure

Your Appeal Rights

Under the Medical Plans

Initial Benefit Determinations

You may request a review of an adverse benefit determination. You may also file a quality of care or general complaint; PHP refers to this as a grievance.

An “adverse benefit determination” means a denial, decrease or termination of a benefit. This includes a failure to provide or make payment – in whole or in part – for a benefit based on:

- A determination that a benefit is limited or not covered by the Plan,
- A determination that a service is experimental, investigational or not medically necessary, and/or
- A 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.

You must file your grievance or appeal within 180 days of the date on the notice of the initial adverse benefit determination or your right to appeal will be forfeited and the initial determination will become final.

How to Submit Grievances or Appeals

If your situation is urgent, you may call a PHP Customer Service representative. Please review the **Urgent Medical Conditions** section for more information.

You may contact a Customer Service representative at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711.

Written grievances or appeals should be sent to:

Providence Health Plan
Appeals and Grievances Department
P.O. Box 4158
Portland, Oregon 97208-4158

You may fax your grievance or appeal to 503-574-8757 or 800-396-4778, or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, Oregon 97005-2359

When you submit your grievance or appeal, please include as much information as possible, including the date and 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 PHP will consider that information in their review process.
- You can be represented by anyone of your choice.
- Request for Claim/Appeal File and Additional Information:
  - You can, upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to PHP's decision at any time before, during, or after the appeal process. This includes any specific internal rule, guidelines, protocol, or other similar criterion relied upon to make the Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable.
  - You also have the right to request free of charge, at any time, the diagnostic and treatment codes and their meanings that are the subject of your claim or appeal.

To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service by a Customer Service representative. PHP will acknowledge all non-urgent pre-service and post-service grievances and appeals within seven days of receipt and notify you of the decision within 30 days (for non-urgent pre-service matters) or 60 days (for non-urgent post-service matters). Urgent medical conditions and concurrent care have different resolution timelines, as noted below.

Urgent Medical Conditions

If you or your health care provider believes your health or that of your covered dependent would be seriously harmed or would subject you or your covered dependent to severe pain that would not be adequately managed by waiting for a decision by PHP on your grievance or appeal, you may request an expedited review by calling Customer Service at 503-574-7500 or 800-878-4445 outside of the Portland area. PHP will conduct a preliminary review to determine whether the appeal is eligible for expedited review. PHP will notify you of the initial determination by phone within 72 hours of receiving your request if your case qualifies for an expedited review, with a letter following by mail.

Grievances and Appeals Involving Prior Authorizations (Non-Urgent) and *Post-Service* Claims

If your grievance or appeal involves a request for a non-urgent medical condition or a ***post-service claim***(s), PHP will notify you of their decision by mail, within 60 days of receiving your request for a first level internal appeal.

Grievances and Appeals Involving Concurrent Care Decisions

If PHP has approved an ongoing course of treatment for you and determines through medical management procedures to reduce or terminate coverage for that course of treatment, they will provide advance notice to you of that decision. You may request reconsideration of their decision by submitting an oral or written request at least 24 hours before the treatment is scheduled to end as previously approved. PHP will conduct a preliminary review to determine whether the appeal is eligible for expedited review and will notify you if the request is not eligible. PHP will then notify you of the decision by phone within 24 hours of receiving your request if your case qualifies for an expedited review, with a letter following by mail.

Authorized Representative

You or your covered dependent may authorize another person to represent you when communicating to the ***Claims Administrator*** regarding specific claims or an appeal. The authorization must be in writing, signed by you or your covered dependent, and include all the information required in an appeal.

You can contact PHP's Customer Service Department to request a Designation of Authorized Representative (DAR) form.

Other forms you may sign at the request of your health care provider do not make your provider an authorized representative. You can revoke the designation of an authorized representative at any time, and you can authorize only one person to act as your representative at a time.

Grievance and Appeals Process

When submitting your grievance or appeal, please advise PHP of any additional information that you want considered in the review process. If your claim involves an out-of-network provider, you should contact that provider's office and arrange for the necessary records to be forwarded to PHP for the review process. You may present your case in writing.

Your grievance or appeal will be reviewed by PHP staff not involved in the initial determination. Once a final determination is made, you will be sent a written explanation of the decision.

If the claim is denied on appeal, you will receive:

- Specific reasons for the denial
- Reference to the specific plan provisions on which the decision is based
- A description of any additional material or information needed from the claimant if the claim was incomplete, and an explanation of why the material or information is necessary. A description of the plan's review procedures and their time limits, including your right to bring a civil action in court under section 502(a)(1)(B) of ***ERISA*** following a claims denial on review
- If an internal rule, guideline, protocol or other similar criterion was relied upon in the denial of the claim, you will be notified that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request (free of charge)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be given an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or notified that such explanation will be provided free of charge upon request
- For medical claims denial involving an ***urgent care claim***, a description of the expedited review process applicable to such claims
- Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable), and the standard, if any, used for deciding the claim are available upon request

For purposes of this Plan, the ***Plan Administrator*** has delegated internal review duties and obligations as described in this section, to Providence Health Plan.

Note: You or your authorized representative must file your appeal within 180 days of the date you receive the adverse benefit determination according to these provisions or the right of appeal will be forfeited.

After you have exhausted your internal appeal rights as described above, you may have additional rights to appeal an adverse benefit decision to an independent external review organization. You may contact PHP for additional information.

Standard 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) medical judgment (as determined by the external reviewer) or (b) rescission of coverage (whether or not the rescission has an effect on any particular benefit at that time), you may request an external review by an Independent Review Organization (IRO). The IRO is an independent review organization that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct external reviews.

For purposes of this Plan, the ***Plan Administrator*** has delegated external review duties and obligations, as described in this section, to Providence Health Plan.

Time Frame for Requesting External Review

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

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

Preliminary Review

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

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

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

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

Assignment to IRO

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

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

Submitting additional Information to IRO

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

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

Scope of IRO Review

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

External Review Decision

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

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

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

Exhaustion of Process

You must exhaust the applicable level(s) of appeal under this Appeal Procedure before you initiate any litigation or other legal proceeding related to your plan benefits. Benefits will be paid under the plan only if the Grievance Committee or, if applicable, the Independent Review Organization (IRO), determines in its discretion that you are entitled to them. Any such determination shall be final and binding. After receiving such a determination, you will have exhausted your administrative remedies under the Plan, and you will have a right to bring an action for benefits under ***ERISA*** Section 502(a)(1)(B). Any legal action taken

against the Plan or its fiduciaries must be filed in a court of law no later than 120 days after the final decision on your claim appeal. If any judicial or administrative proceeding is undertaken, the evidence presented will be strictly limited to the evidence timely presented to the ***Claims Administrator*** or IRO, if applicable.

Under the Dental PPO Plan

Initial Benefit Determinations

An initial benefit determination takes place at the time of claim submission to Delta Dental of Washington (DDWA) for payment modification or denial of services. In accordance with regulatory requirements, DDWA processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written Explanation of Benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

Appeals of Denied Claims

How to contact DDWA

DDWA will accept notice of an Urgent Care or Appeal if made by you, your covered dependent, or an authorized representative of your covered dependent orally by calling 800-554-1907 or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents or other information that you believe supports your claim.

Authorized Representative

You may authorize another person to represent you or your dependent and receive communications from DDWA regarding you or your dependent's specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed authorized representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

Informal Review

If your claim for dental benefits has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to initiate an appeal. Your first step in the appeal process is to request an informal review of the decision. Either you, or your authorized representative, must submit your request for a review within 180 days from the date of the adverse benefit determination. If not submitted within 180 days, the right to appeal will be forfeited.

A request for a review may be made orally or in writing, and must include the following information:

- Your name, the patient's name (if different) and ID number
- The group name and number
- The claim number (from your explanation of benefits form)
- The name of the dentist

Please submit your request for a review to:

Delta Dental of Washington
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

You may include any written comments, documents or other information that you believe support your claim.

DDWA will review your request and send you a notice within 14 days of receiving your request. This notice will either be the determination of their review or a notification that they will require an additional 16 days, for a total of 30 days. When the review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request a formal appeal. Your formal appeal will be reviewed by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the previous review.

Your request for a review by the Appeals Committee must be made within 90 days of the date of the letter notifying you of the informal review decision. Your request should include the information submitted with your information review request plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim within 30 days of receiving your request. Upon completion of their review, the Appeals Committee will send you written notification of their decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regard maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulations.

The decision of the Appeals Committee is final. If you disagree with the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

No lawsuit shall be brought against the Plan, the Company, the ***Plan Administrator*** or ***Claims Administrator*** after 120 days from receipt of the final decision on a claim appeal.

Under the Vision Plan

Initial Benefit Determinations

VSP will pay or deny claims within 30 days of the receipt of the claim. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than 15 days.

If your, or your family member's, claim for benefits is denied by VSP in whole or in part, VSP will send in writing the reason or reasons for the denial.

Appeals of Denied Claims

A request for review must be submitted within 180 days of the date your claim was denied. If an appeal is not submitted within 180 days, the right to appeal will be forfeited.

A request for a review may be made orally or in writing, and must include sufficient information to identify the covered person for whom a claim for benefits was denied, including:

- Name of the enrolled employee
- ID number of the enrolled employee
- Patient's name and date of birth
- Name of the provider of services
- Claim number

You may state the reasons you believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed.

All requests for appeals should be submitted to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. VSP's determination, including specific reasons for the decision, shall be provided and communicated to you or your family member within 30 days after receipt of a request for appeal.

If you as the patient disagree with VSP's determination, you may request a second level appeal within 60 days from the date of the determination. VSP shall resolve any second level appeal within 30 days.

When you have completed all appeals mandated by the Employee Retirement Income Security Act of 1974 (***ERISA***), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You can contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a) (1)(B)) [29 U.S.C. 1132(a)(1)(B)], the covered person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and you as the covered person disagrees with the outcome. No lawsuit shall be brought against the Plan, the Company, the ***Plan Administrator*** or ***Claims Administrator*** after 120 days from receipt of the final decision on a claim appeal.

Under the Caregiver Assistance Program

Contact Lyra at 844-311-6223 for assistance with benefit claims and appeals as of February 1, 2021, or Optum at 844-875-5716 if assistance is needed prior to February 1, 2021.

Under the Life and Accidental Death and Dismemberment Plan

Initial Benefit Determinations

Securian Life will review the claims for benefits and notify you or your ***beneficiary*** of its decision in a period of time not to exceed seven calendar days from receipt of all necessary information and documents to complete a full review.

If Securian Life denies the claim, notification of the claims decision will state the reason for denial and reference the specific Plan provision(s) on which the denial is based. If the denial is due to insufficient information, the notification will describe what additional information is needed and why. The notification will also include a description of the Plan review procedures and time limits, including the right to a civil action. See section below for further details on appeals of denied claims.

Appeals of Denied Claims

In the event a claim has been denied in whole or in part, you or, if applicable, your ***beneficiary*** can request a review of your claim by Securian Life. This request for review should be sent in writing within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim.

When requesting a review, in writing, state the reason you or, if applicable, your ***beneficiary*** believe the claim was improperly denied and submit any comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, Securian Life will provide you free of charge with copies of relevant documents, records and other information.

Securian Life will re-evaluate all the information provided in writing and will conduct a full and fair review of the claim. The person who reviews your appeal will not be the same person as the person who made the initial decision to deny your claim; the reviewer will also not be a subordinate of the person who initially denied your claim. You or, if applicable, your ***beneficiary*** will be notified of the decision within a reasonable period not to exceed 60 days from the date Securian Life received your request for review, unless Securian Life notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If Securian Life denies the claim on appeal, a final written decision will be sent stating the reason(s) why the claim you or your ***beneficiary*** appealed is being denied; reference any specific Plan provision(s) on which the denial is based; any voluntary appeal procedures offered by the Plan; and a statement of your right to bring a civil action within 120 days if your claim is denied after an appeal.

If an internal rule, protocol, guideline or other criteria was relied upon in denying your claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such was relied upon and you may request a copy free of charge.

Note: You may access the ***HR Service Portal*** to view the insurance certificate for additional details. The insurance certificate governs the terms of coverage and administration.

In the event of a conflict between this summary and the certificate, the certificate shall dictate the insurance provisions, exclusions, all limitations and terms of coverage.

Under the Long-Term Disability Plan

Initial Benefit Determinations

New York Life (NYL), formerly known as Cigna, will review the claims for benefits and notify you of its decision no later than 50 days after the claim is acknowledged. If unable to make a determination, NYL will notify you of the claim status on the 30th day and every 30 days thereafter. If more than 50 days are needed to make a determination, NYL will notify you of the extension due to special circumstances beyond the control of the plan.

If NYL denies the claim, written or electronic notification of the claims decision will:

- State the specific reason(s) for the determination
- Reference specific Plan provision(s) on which the determination is based
- Describe additional material or information necessary to complete the claim and why such information is necessary
- Describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court
- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request)

Appeals of Denied Claims

In the event a claim has been denied in whole or in part, you can request a review of your claim by NYL. This request for review should be sent in writing within 180 days after you receive notice of denial of the claim to the address specified in the notice or you will forfeit your right to appeal.

When requesting a review, in writing, state the reason you believe the claim was improperly denied and submit any comments, documents, records or other information you deem appropriate. You must include your name, the plan name and reference the initial decision. Upon your written request, NYL will provide you, free of charge, with copies of relevant documents, records and other information.

NYL will re-evaluate all the information provided in writing and will conduct a full and fair review of the claim. You will be notified of the decision within a reasonable period not to exceed 45 days from the date we received your request for review, unless NYL notifies you within that period that there are special circumstances requiring an extension of time of up to 45 additional days.

Note: You may access the ***HR Service Portal*** to view the insurance certificate for additional details. The insurance certificate governs the terms of coverage and administration. In the event of a conflict between this summary and the certificate, the certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage.

Under the Voluntary Individual Disability Insurance Plan

Refer to your individual certificate of insurance or contact UNUM for assistance with benefit claims and appeals. The insurance certificate governs the terms of coverage and administration.

Under the Health Care Flexible Spending Account (FSA)

If your claim under the Health Care FSA is denied, you may appeal that claim. The claim appeal needs to be submitted within 180 days of the date the denial notice was sent or you will forfeit your right to appeal. You will be notified of the decision within 60 days of receiving your request for a first-level appeal or within

60 days of receiving your request for a second-level appeal. If the claim is denied on appeal, you will receive:

- The specific reason(s) for the denial and reference to the pertinent participating benefit provisions upon which the denial is based
- A description of any additional material or information you need to submit to complete your claim and the reasons why such material or information is necessary
- An explanation of the Plan's claims appeal procedures, including any applicable time limits

Upon request, you may also receive:

- Reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits (information is also available online by accessing the denied claim on the member portal)
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge
- An explanation of the IRS Regulation relied on in the determination or a statement that such explanation will be provided free of charge

Once you have completed the appeals process described above, if the matter is still unresolved to the satisfaction of all parties, you have the right to bring an action under Section 502(a)(1) (B) of ***ERISA***.

No lawsuit shall be brought against the Plan, the ***Plan Administrator*** or a ***Claims Administrator*** after 120 days from receipt of the final decision on a claim appeal.

Statement of ERISA Rights

As a participant in the Providence Health & Services System Health and Welfare Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA) and under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ERISA provides that all plan participants are entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the ***Plan Administrator's*** office and at other specified locations, such as worksites, all documents governing the Plan, including insurance certificates and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ***Plan Administrator***, copies of documents governing the operation of the Plan, including insurance certificates and collective bargaining agreements, and copies of the latest annual report and updated *Summary Plan Description* (SPD). The ***Plan Administrator*** may make a reasonable charge for the copies.
- Receive a summary of the Plan's Annual Return/Report of Employee Benefit Plan (Form 5500). The ***Plan Administrator*** is required by law to furnish each participant with a copy of a summary annual report.

Continue Group Health Care Coverage

Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Note: Adult Benefit Recipients (ABRs) and/or their unmarried children are not eligible for COBRA or other continuation coverage if they lose eligibility for active coverage (i.e. if the relationship ends, they become eligible for other medical coverage or their unmarried child turns age 26). If the employee loses eligibility, the employee may continue coverage for the ABR and their unmarried children as part of their own COBRA enrollment.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ***ERISA*** imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ***ERISA***.

Enforcement of Your Rights

If your claim for a welfare 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.

Under ***ERISA***, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may, in its sole discretion, require the ***Plan Administrator*** to provide the materials and pay you up to $110 a day starting with the 31st day after the request was made.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the ***Plan Administrator***. If you have any questions about this statement or about your rights under ***ERISA*** or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

Plan Benefits Can Be Changed or Discontinued

The Plan Sponsor or its designee reserves the right to alter, delete, cancel, and otherwise change plan benefits at any time. If any plan is terminated, coverage for you and your eligible family members will end. However, benefits for any legitimate claims incurred before a plan's termination will be provided in accordance with plan provisions.

Note: For information as to when the Plan can rescind your coverage retroactively, please review the Termination of Coverage section in the General Medical, Dental, and Vision Information chapter. Rescission of coverage and eligibility determinations constitute adverse benefit determinations with appeal rights.

Effective Date of Plan Changes

Any changes to the Plans will take effect on the date established by the Plan Sponsor or ***Plan Administrator***. Any material reductions to the Plans (that involve terms or conditions outlined in the summary of benefits coverage) will be reported to you within 60 days prior to when the change takes effect.

If any conflicts arise between this Summary Plan Description and the applicable insured contracts, the insured contracts will govern.

Non-Discrimination Testing

Federal legislation prohibits certain health and welfare plans from being designed or operated in a non-discriminatory manner in favor of highly compensated employees or key employees, as defined by the Internal Revenue Code. In order to determine if the plans meet the non-discriminatory requirements, testing is performed. If the Plan does not meet the non-discriminatory requirements, highly compensated employees will owe income tax on the value of their benefits.

If the benefits plan fails to pass the non-discrimination tests, and you are considered to be highly compensated, you will be informed of any additional income to be reported on your W-2 or changes to be made to your benefit elections. Benefit changes may need to be made retroactively to bring the benefits into compliance.

HIPAA – Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

If you have any questions about this notice, please contact the Privacy Contact listed below.

Plan	Providence Health & Services Health and Welfare Plan
Privacy Contact	**Privacy Contact** Benefits Consultant, Compliance Providence St. Joseph Health Total Rewards - Caregiver Benefits 2001 Lind Avenue SW, Suite 500 Renton, Washington 98057 Contact through the Benefits Service Center: 88-615-6481 **Privacy Officer** Chief Privacy Officer Providence St. Joseph Health 2001 Lind Avenue SW, Suite 100 Renton, WA 98057 Contact through Integrity Line: 888-294-8455 or use Web-based reporting tool, Integrity Online

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules (collectively "HIPAA"), this notice describes the legal obligations of the Plan Sponsor and its affiliates or their designee (collectively "Plan Sponsor") and the health benefits programs sponsored by them (collectively referred to as the "Health Plans") regarding your protected health information ("PHI") held by the Plan.

Among other things, this notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

PHI means any information, including demographic information, which is created or received by a covered entity or an employer and relates to:

- The past, present, or future physical or mental health or condition of an individual
- The provision of health care to an individual
- The past, present, or future payment for the provision of health care to an individual

- The identity of the individual or for which there is a reasonable basis to believe the information can be used to identify the individual

PHI includes information concerning persons living or deceased and may be written, oral, or electronic.

We understand that your PHI is personal. We are committed to protecting your PHI. We create a record of the health care claims reimbursed under the Plan for plan administrative purposes. This notice applies to all of the health records we maintain in connection with the Plan's group health plan benefits. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your PHI created in the doctor's office or clinic. An insurer that insures group health plan benefits of the Plan may have different policies or notices regarding the insurer's use and disclosure of your PHI created by the insurer.

This notice tells you about the ways in which the Plan may use and disclose your PHI. It also describes our obligations and your rights regarding the use and disclosure of your PHI.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your PHI
- Provide you with certain rights with respect to your PHI
- Provide you with this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the Plan's Notice of Private Practices that are currently in effect

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures, we explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Payment (as described in this notice). The Health Plans may use and disclose your PHI to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. Likewise, we may share your PHI with another entity to assist with the adjudication or subrogation of health claims or to another plan to coordinate benefit payments.

Health Care Operations (as described in this notice). The Health Plans may use and disclose your PHI for health care operations – for example, to arrange for medical review, for disease management, to conduct quality assessment and improvement activities, or for underwriting. However, the Health Plans are prohibited from using or disclosing your genetic information for underwriting purposes. The Health Plans also may disclose your PHI to another health plan or a health care provider that has or had a relationship with you for it to conduct quality assessment and improvement activities: for accreditation, certification, licensing, or credentialing activities; or for the purpose of health care fraud and abuse detection or compliance – for example, for the other health plan to perform case management or health care provider performance evaluations, or for the health care provider to evaluate the outcomes of treatments or conduct training programs to improve health care skills.

Treatment (as described in this notice). The Health Plans may use or disclose your PHI to obtain payment for your coverage and to determine and fulfill the Health Plans' responsibility to provide health benefits – for example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have.

The Health Plans also may disclose your PHI to another health plan or to a health care provider for its payment activities – for example, for the other health plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you.

To Comply with Law. The Health Plans may use and disclose your PHI to the extent required to comply with applicable law.

For Plan Administration. The Health Plans may disclose your PHI to certain employees or other individuals under the Plan Administrator's control to allow them to administer the Health Plans. The Plan Administrator and your employer cannot use your PHI obtained from the Health Plans for any employment-related actions without your written authorization.

In addition, the Plan Administrator, on behalf of plan sponsors, may use or disclose "summary health information" for purposes of obtaining premium bids or modifying, amending, or terminating the Health Plans. Summary health information is information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom benefits are provided under the Health Plans and from which the individual identifying information, except for five-digit zip codes, has been deleted. The Plan Administrator also may use and disclose Health Plan eligibility and enrollment/disenrollment information – for example, for payroll processing.

Third Party Providers (Business Associates). The Health Plans contract with third party administrators and various service providers, called "business associates," to perform certain plan administration functions. The Health Plans' business associates will receive, create, use, and disclose your PHI, but only after the business associates have agreed in writing to appropriately safeguard and keep confidential your PHI.

Marketing Communications. The Health Plans may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be useful to you. The Health Plans may also use and disclose your PHI to communicate face-to-face with you to encourage you to purchase or use a product or service that is not part of the health benefits provided by the Health Plans, or to provide a promotional gift of nominal value to you.

Disclosures in Connection with Regulatory Inquiry. The Health Plans may disclose your PHI to the U.S. Department of Health and Human Services in connection with an inquiry or review of the Health Plans' compliance with the HIPAA privacy rules.

Judicial and Administrative Proceedings. The Health Plans may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Workers Compensation. The Health Plans may disclose your PHI as necessary to comply with workers' compensation or similar laws or programs.

Research. The Health Plans may use or disclose your PHI for research purposes, as long as certain privacy-related standards are satisfied.

Public Health. The Health Plans may use or disclose your PHI for certain public health activities, including to a public health authority for the prevention or control of disease, injury, or disability; to a proper government or health authority to report child abuse or neglect; to report reactions to medications

or problems with products regulated by the Food and Drug Administration; to notify individuals of recalls of medication or products they may be using; to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition; or to provide immunization information to a school about a student or potential student.

Disclosures to Your Personal Representative and Family Members

Personal Representative. The Health Plans will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Health Plans must be given written documentation that supports and establishes the basis for the personal representation. The Health Plans may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Health Plans determine, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Family Members and Friends. The Health Plans may disclose your PHI to your family members, close friends, or other persons involved in your health care if you are present and you do not object to the disclosure (or if it can be inferred that you do not object), or, if you are not present or are unable to object due to incapacity or emergency, the disclosure is in your best interest. Following your death, the Health Plans may disclose your PHI to your family members, close friends, or other persons who were involved in your health care unless doing so would be against your stated preferences. Disclosure will be limited to your PHI that is directly relevant to the person's involvement in your health care.

Other Situations When We May Use or Disclose Your Protected Health Care Information

In addition, the Health Plans may use or disclose your PHI in limited circumstances as permitted or required by law, including:

- For certain health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services
- To police or other law enforcement officials as required by law or in compliance with a court order or other process authorized by law
- To an appropriate government authority to report suspected instances of abuse, neglect, or domestic violence
- To prevent or lessen a serious and imminent threat to the health and safety of an individual or the public
- If you are deceased, to allow a coroner or medical examiner to identify you or determine your cause of death, for tissue donation purposes, or to allow a funeral director to carry out his or her duties
- For purposes of public safety or national security.
- To specialized government units, such as the U.S. military or U.S. Department of State, for certain government purposes

State law may further limit the permissible ways the Health Plans use or disclose your PHI. If an applicable state law imposes stricter restrictions, the Health Plans will comply with that state law.

Uses and Disclosures With Your Written Authorization

A Health Plan may use or disclose your PHI for a purpose other than as described above only if you give the Health Plans or their business associates your written authorization. Most uses and disclosures of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures that constitute a sale of your PHI require your authorization under the HIPAA privacy rules.

If you provide a Health Plan or its business associate with your authorization to use or disclose your PHI, you may revoke your authorization at any time by delivering a written revocation statement to the Health Plan or business associate. If you revoke your authorization, the Health Plans will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, the Health Plans cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

Your Individual Rights

The HIPAA privacy rules provide you with certain rights regarding your PHI.

Right to Request Additional Restrictions. You may request restrictions on a Health Plan's use and disclosure of your PHI. While the Health Plans will consider all requests for additional restrictions carefully, the Health Plans are not required to agree to a requested restriction. If you wish to request restrictions on a Health Plan's use and disclosure of your PHI, you may obtain a request form from the Health Plan's Privacy Contact. Most PHI relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the Health Plans. To request restrictions on the use or disclosure of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request restrictions, or for contact information for the Health Plan vendors, call or write the Privacy Contact (contact information below).

Right to Receive Confidential Communications. You may request to receive your PHI by alternative means of communication or at alternative locations. Your request must specify how or where you wish to be contacted. The Health Plans will try to accommodate any reasonable request for confidential communication. Please note that in certain situations, such as with respect to eligibility and enrollment information, the Health Plans are obliged to communicate directly with the employee rather than a dependent unless your request clearly states that disclosure of that information through the normal methods could endanger you. If you wish to request confidential communication of your PHI, you may obtain a request form from the Health Plans' Privacy Contact. Most communications of PHI relating to your health benefits are made by third party vendors (business associates) that administer the Health Plans. To request confidential communication of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request restrictions, or for contact information for the Health Plan vendors, call or write the Privacy Contact (contact information below).

Right to Inspect and Copy Your PHI. You may request access to certain Health Plan records that contain your PHI in order to inspect and request copies of those records. If you request copies, the Health Plans may charge you copying, mailing, and labor costs. To the extent that your PHI is maintained electronically, you may request that the Health Plans provide a copy to you or to a person or entity designated by you in an electronic format. Under limited circumstances, a Health Plan may deny you access to a portion of your records. If you desire access to your records, you may obtain a request form from the Privacy Contact. Most PHI relating to your health benefits is created or maintained by third party vendors (business associates) that administer the Health Plans. For access to that information, you may wish to contact the vendors directly. For more information on your right to inspect and request copies of your PHI, or for contact information for the Health Plan vendors, call or write to the Health Plans Privacy Contact.

Right to Amend Your Records. You have the right to request that the Health Plans amend your PHI maintained in the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Health Plans and any other records used by or for the Health Plans to make decisions about your benefits. The Health Plans will comply with your request for amendment unless special circumstances apply. A Health Plan may deny your request for amendment if you do not provide a reason to support your request or if the Health Plan believes that the information is accurate.

In addition, a Health Plan may deny your request if you ask it to amend information that was created by another health plan or health care provider (but the Health Plan will inform you of the source of the information, if known). If your physician or other health care provider created the information that you desire to amend, you should contact the health care provider to amend the information.

To make a request for amendment, you may obtain a request form from the Health Plans' Privacy Contact. Most PHI relating to your health benefits is created or maintained by third party vendors (business associates) that administer the Health Plans. To request amendment of that information, you may wish to contact the vendors directly. For more information on your right to request amendment of your PHI, or for contact information for the Health Plan vendors, call or write to the Health Plans' Privacy Contact (contact information below).

Right to an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by the Health Plans made within six years of the date of your request. The accounting will generally be provided free of charge, but if you request an accounting more than once during a twelve (12) month period, the Health Plans may charge you a reasonable fee for any subsequent accounting statements. You will be notified of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses. The accounting will not include all disclosures of your PHI. For example, the accounting will not include disclosures (i) to carry out treatment, payment or health care operations activities; (ii) made to you; (iii) made to friends or family members involved in your care; (iv) made pursuant to your written authorization; (v) for national security or intelligence purposes; or (vi) to correctional institutions or law enforcement officials. If you wish to request an accounting, you may obtain a request form from the Health Plans' Privacy Contact. Most PHI relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the Health Plans. For an accounting of disclosures by a Health Plan vendor, you may wish to contact the vendor directly. For more information on your right to request an accounting, or for contact information for the Health Plan vendors, call or write to the Health Plans' Privacy Contact (contact information below).

Right to a Paper Copy of This Notice. You may obtain a paper copy of this Notice upon request to the Benefits Service Center.

Right to Notification of a Breach of Your PHI. You will be notified in the event of an improper use or disclosure of your PHI if a Health Plan determines that the privacy of your PHI was likely compromised.

Personal Representatives. You may exercise your rights through your personal representative who has authority under applicable state law to make health-related decisions on your behalf. Your personal representative will be required by the Health Plans to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or evidence that you are the parent of a minor child. The Health Plans reserve the right to withhold your PHI from your personal representative in certain limited circumstances.

For Further Information; Complaints. If you would like additional information about your privacy rights, contact the System Privacy Officer. If you are concerned that a Health Plan has violated your privacy

rights, or if you disagree with a decision that a Health Plan made about access to your PHI or any of your other rights described above, you should contact the Privacy Officer.

The Plan Administrator and the Health Plans take your complaints very seriously. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. Upon request, the System Privacy Officer will provide you with the correct address for the Secretary. **Neither the Plan Administrator or your employer or the Health Plans will retaliate against you if you file a complaint with the Privacy Officer or the Secretary.**

Changes to This Notice. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future.

Right to Change Terms of this Notice. This Notice is subject to change. If the Health Plans revise this Notice, they may make the new Notice terms effective for all of your PHI that they maintain, including any information created or received prior to issuing the updated Notice. If the Health Plans make a material change to this Notice, you will be notified of the change if you are then covered by a Health Plan. In addition, any new Notice will be posted on the ***HR Service Portal.*** You may also obtain the most current copy of the Notice by contacting the Benefits Service Center.

Keep Your Health Plans Informed of Address Changes

In order to protect your and your family's Health Plan privacy rights, you should maintain a current address in the payroll system following the procedures designated by your employer. In the event that your PHI has been breached, the Health Plans will notify you at your address on record.

Questions

If you have questions about this notice, please contact the Benefits Service Center at 888-615-6481 or submit an HR Inquiry ticket after logging on to the ***HR Service Portal***. Your inquiry will be forward to the Benefits Consultant, Compliance.

Effective Date

This notice of Privacy Practices becomes effective on January 1, 2021.

Separation of Employer and the Group Health Plan

The following classes and their successor titles of Providence Shared Services employees and other persons or vendors under the control or general oversight of the ***Plan Administrator*** shall be given access to protected health information:

- SVP, Total Rewards -Talent Acquisition
- VP, Senior Employee Benefits Counsel
- VP, Caregiver Benefits
- Benefits Coordinator
- Executive/Director, Caregiver Health and Welfare Benefits
- Senior/Manager, Caregiver Benefits
- Consultant, Caregiver Benefits Compliance
- Principal Consultant, Caregiver Benefits
- Senior Analyst, Caregiver Benefits
- Benefits Analyst, Caregiver Benefits

- Director, Caregiver Well-Being
- Senior/Consultant, Caregiver Well-Being
- Financial Manager, limited to benefit budget administration
- Financial Partner/Financial Trust Analyst, Sr., limited to plan financial analytics and administration
- Senior Manager HRSC (Human Resources Service Center)
- Senior/Manager HRSC Operations and Vendor Services
- HRSC Tier 3 Specialists
- Senior/HRSC Advisor, Customer Service Specialist and Electronic Files Specialists within the HRSC as authorized to perform plan administrative functions
- Human Resource Information Systems (HRIS), limited to plan administration support at the request of, Exec. Director, Caregiver Health and Welfare Benefits or Senior Manager, Caregiver Benefits
- Regional and PSJH Privacy Officers
- Internal Auditors actively performing audits for the Plan
- Department of Legal Affairs attorneys
- Risk Management, PSJH

The Plan Administrator shall restrict the access to and use of protected health information by such employees and other persons described above to the Plan administration functions that Providence Shared Services performs for the Plan, including payment and health care operations.

Glossary

You may see definitions for these terms within the *Summary Plan Description*, on your Explanation of Benefits, or in other benefits materials.

You may see definitions for these terms within the Summary Plan Description, or in other benefits materials.

Beneficiary
The person(s) or other entity you designate to receive your life insurance, Accidental Death and Dismemberment insurance benefits if you die.

Claims Administrator
A third party administrator or insurer designated by the plan administrator or its delegate to review and process claims for benefits under the Plan.

ERISA
The federal Employee Retirement Income Security Act of 1974, as amended, which governs plan administration, supervision and management.

Fiduciary
As defined by ERISA:

- A person who exercises discretionary authority or control over the management of an ERISA plan or its assets or has discretionary authority or responsibility in Plan administration.

HR Service Portal
Electronic resource for benefits information available at **hrforcaregivers.org**. Health and Welfare benefit elections can be entered by selecting the *Benefits – enroll, review or update (BenefitConnect)* link on the homepage under **External Links**. Access to the Benefits Service Center for questions is also available by navigating to the **Request HR Help > Benefits > Benefits Questions**. Other HR tools and resource materials are available on the portal.

Plan Administrator
The Plan Administrator is the sole fiduciary of the Plan and has all discretionary authority and control over the operation and administration of the Plan. The Plan Administrator has the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, and unless there was an abuse of discretion, such discretionary determinations regarding plan terms and eligibility shall be binding upon all participants and upon the employers.

The Plan Administrator may choose to hire a consultant and/or contract administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner.

Post-service claim
Any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.

Pre-service claim
Any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.

Urgent care claim

A claim for medical care or treatment with respect to which application of the time periods for making non-urgent care decisions:

- Would seriously jeopardize the claimant's life, health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested

Welfare Plan Information

Name of Plan: **Plan Number:**	Providence Health & Services Health and Welfare Plan 501
Type of Plan:	The Plans are group health and welfare plans providing the following types of benefits: Self-Insured Benefits • Medical Insurance • Dental Insurance • Vision Insurance • Health Care and Dependent Care Flexible Spending Accounts • Pharmacy under the Blue Shield HMO plan (where offered in Southern California) Insured Benefits • Health Maintenance Organization (HMO) Medical (where offered in Washington state and Southern California) • Dental HMO (DHMO) • Basic Employee Life Insurance • Basic Accidental Death and Dismemberment Insurance • Supplemental Accidental Death and Dismemberment Insurance • Supplemental Employee and Dependent Life Insurance • Long Term Disability Insurance • Voluntary Individual Disability Insurance • Caregiver Assistance Program • Short Term Disability Insurance (for specified legacy groups)
Plan Year:	The Plan Year is January 1 to December 31.
Plan Administrator: **Plan Sponsor:**	Total Rewards Management Committee, c/o Senior Benefits Counsel 2001 Lind Avenue SW, Renton, WA 98057 **Providence Health & Services**, 2001 Lind Avenue SW, Renton, WA 98057
Employer Identification Number:	95-3589356

Contributions, Funding, and Administration:	Medical, Dental and Vision benefits are self-insured and fully insured. Pharmacy benefits under the insured HMO plans, where offered in Southern California, are self-insured. Self-insured claims paid under the Plan are funded with monies received from plan participants and from the organization's general assets. Fully insured HMO and DHMO benefits are provided under a group insurance contract and funded with insurance premiums received from the organization which includes contributions from plan participants and the organization's general assets. The Health Care Spending Accounts are funded by pre-tax participant contributions. Medical and pharmacy (self-insured) claims are paid by: Providence Health Plan P.O. Box 4447 Portland, OR 97208 Toll-free: 1-800-878-4445 Kaiser of Washington HMO – where offered in Washington state P.O. Box 34590 Seattle, WA 98124-1590 Toll-free: 1-888-901-4636 FirstCare Administrative Services (medical claims) – where EPO medical plan offered in Texas 12940 N. Hwy 183 Austin, TX 78750 Toll-free: 1-888-249-7366 Dental (self-insured PPO plan) claims are paid by: Delta Dental of Washington P.O. Box 75983 Seattle, WA 98175 Toll-free: 1-800-554-1907 Vision claims are paid by: Vision Service Plan P.O. Box 385018 Birmingham, AL 35238-8501 Toll-free: 1-800-877-7195 Health Care and Dependent Care FSA claims are paid by: HealthEquity, Inc. 15 W Scenic Pointe Dr., Ste 100 Draper, UT 84020 Toll-free: 877-372-6667 Pharmacy claims under the Blue Shield HMO (Southern California) and FirstCare (Texas) plan are paid by: Express Scripts, Inc. One Express Way St. Louis, MO 63121 866-340-1551 As Claims Administrators for the Plans described above, these entities—subject to the overall authority of the Plan Administrator—have discretionary authority to interpret plan provisions, to decide questions of eligibility for coverage or benefits under the Plan, to adjudicate claims, and to decide any appeals of denied claims.

	All other benefits are insured through insurance contracts paid for by employer and/or employee contributions. For these Plans, the Plan Administrator has delegated authority to the insurance company to administer benefit claims under the Plans. California Health Maintenance Organization Medical (Blue Shield of California) insurance benefits (where applicable in Southern California) are funded, administered, and paid through the purchase of insurance. Benefits are guaranteed in accordance with the provisions of the insurance contract. Blue Shield of California 50 Beale Street, 22nd Floor San Francisco, CA 94105 DeltaCare USA DHMO Dental insurance benefits (where applicable) are funded, administered, and paid through the purchase of insurance. Benefits are guaranteed in accordance with the provisions of the insurance contract. Dentegra Insurance Company 560 Mission Street, Suite 1300 San Francisco, CA 94105 Basic Employee Life, Supplemental Employee Life Insurance, Dependent Life Insurance, Supplemental Accidental Death and Dismemberment Insurance, Short Term Disability, Long-Term Disability and Voluntary Individual Disability benefits are funded, administered, and paid through the purchase of insurance. Benefits are guaranteed in accordance with the provisions of the insurance contract. Life Insurance and Accidental Death & Dismemberment Insurance: Securian P.O. Box 64114 St. Paul, MN 55164-0114 Long-Term Disability and Short Term Insurance: Cigna P.O. Box 29063 Glendale, CA 91209 Voluntary Individual Disability Insurance: UNUM Benefits Center P.O. Box 100262 Columbia, SC 2902-3262
	Caregiver Assistance Program benefits are funded, administered, and paid through a service agreement. Benefits are guaranteed in accordance with the provisions of the agreement Effective February 1, 2021: Lyra Health, Inc. 287 Lorton Avenue Burlingame, CA 91010 Prior to February 1, 2021: United Behavioral Health “Optum” 425 Market Street San Francisco, CA 94105

Agent for Service of Legal Process:	The registered agent on behalf of the Plan Administrator and Plan Sponsor is: Business Filings Incorporated 505 Union Ave SE #120 Olympia, Washington 98501
Named Fiduciary:	The Total Rewards Management Committed is the named fiduciary for most of the health and welfare plans as defined in ERISA. The fiduciary acts on your behalf to make sure the Plans are administered fairly, honestly, and in accordance with legal standards and the terms of the plan documents. In exercising fiduciary responsibilities, the Plan Administrator will have discretionary authority (a) to determine whether and to what extent Participants and beneficiaries are entitled to plan benefits, and (b) to construe the Plan terms. The Plan Administrator will be deemed to have properly exercised such discretionary authority unless the Plan Administrator has abused discretion hereunder by acting arbitrarily and capriciously. Blue Shield of California is the named claims fiduciary for the Health Maintenance Organization medical plans in California, as defined in ERISA. Blue Shield will administer the Plans in accordance with ERISA and has discretionary authority to make decisions on claims appeals and to interpret the terms of the Health Maintenance Organization plans. Delta Dental/Dentegra is the named claims fiduciary for the DeltaCare USA Dental HMO, as defined in ERISA. Delta Dental will administer the Plans in accordance with ERISA and has discretionary authority to make decisions on claim appeals and to interpret the terms of the DHMO Plans. Securian is the named claims fiduciary for the Basic and Supplemental Life and Accidental Death & Dismemberment Plans, as defined in ERISA. Securian will administer the Plans in accordance with ERISA and has discretionary authority to make decisions on claim appeals and to interpret the terms of the Plans. Cigna is the named claims fiduciary for the Short Term Disability and Long Term Disability insurance, as defined in ERISA. Cigna will administer the Plans in accordance with ERISA and has discretionary authority to make decisions on claim appeals and to interpret the terms of the Plans. UNUM is the named claims fiduciary for the Voluntary Individual Disability Insurance plans as defined in ERISA. UNUM will administer the Plan in accordance with ERISA and has discretionary authority to make decisions on claim appeals and to interpret the terms of the Plan. Refer to the certificate of insurance issued by UNUM for claims information. Effective 2/1/21, Lyra Health is the claims fiduciary for the Caregiver Assistance Program. Lyra will administer the Plan in accordance with ERISA and has discretionary authority to make decisions on claim appeals and to interpret the terms of the Caregiver Assistance Program. Prior to 2/1/21, United Behavioral Health “Optum” was the claims fiduciary for the Caregiver Assistance Program.

Appendix

The following materials are incorporated into the Providence Health & Services Summary Plan Description:

1. Evidence of coverage documents/plan summaries, as provided by the insurance carrier or administrator for:
    a. DeltaCare USA DHMO Evidence of Coverage (EOC) and Disclosure Form*

The benefits enrollment system will show all plan options available to you. Please contact the Benefits Service Center at 888-615-6481 with questions or to request a copy of any materials if you are unable to download from the system.

*For the DeltaCare USA DHMO Evidence of Coverage (EOC) and Disclosure Form (also referred to as benefits booklet), contact the Benefits Service Center for the EOC that applies to the state I which you live.

Appendix 2

Summary of Material Modification (SMM)

Summary of Material Modification (SMM) are documents that modify the Plans described within the Summary Plan Description (SPD) following initial publishing. See the pages that follow for SMMs pertinent to this SPD.

Summary of Material Modification to the Providence Health and Services Health and Welfare Plan

This Summary of Material Modification ("SMM") describes changes to the 2021 Providence Health and Services Health and Welfare Plan ("Plan") and supplements the Oregon Summary Plan Description ("SPD") for the Plan. The date in which these plan changes are implemented is indicated below.

Please read this SMM carefully and keep this document with your SPD and other important Plan information for future reference. In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM shall govern with respect to the matters described herein.

Medical – HRA, HSA and EPO (Oregon) Medical Plans

Medical Plans

In alignment with the Families First Coronavirus Response Act (FFCRA), enacted March 18, 2020, and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), enacted March 27, 2020, the Plan is amended as follows:

The medical plans will cover COVID-19 diagnostic testing and items or services related to COVID-19 diagnostic testing at 100% This means no deductible, coinsurance or copayments will apply.

Effective March 1, 2020*

Items and services furnished to an individual during a health care provider office visit (which may include in-person visits or Express Care Virtual**) urgent care center visits, emergency room visits or drive-through screening and testing site visits, that result in an order for or administration of a COVID-19 diagnostic test, are covered at 100%, if such items and services related to the furnishing or administration of a COVID-19 diagnostic test or the evaluation of an individual to determine if a COVID-19 diagnostic test is needed.

Prior authorization, notification and other medical management requirements are waived.

Inpatient and outpatient facility and professional services related to COVID-19 diagnosis and treatment are covered at 100%.

** Express Care Virtual will be covered at 100%, without satisfying the deductible, for all diagnoses under the HSA Medical Plan until Dec. 31, 2021 and for the period April 1, 2022 through Dec. 31, 2022.

*If your medical plan is administered by…	Here is the time period your COVID-19 related services claims will be paid at 100%
Providence Health Plan	Dates of service through December 31, 2021 (extended through December 31, 2022 for in-network treatment.)

The Plan will comply with the national public health emergency declaration provisions regarding coverage of the COVID-19 vaccine as preventive care.

Effective January 1, 2021

Medical – HRA, HSA and EPO (Oregon) Medical Plans

Medical Benefits Exclusions

The exclusion for orthoptics is removed. Orthoptics and vision therapy are covered under the medical diagnostic service. The new exclusion reads:

- Routine vision exams and the fitting of eyeglasses, lenses or supplies

Long-term Disability

Other Income Sources

The following sentence is removed to conform with the terms of insurance coverage:

Benefits will not be reduced by your Social Security income if your disability begins after age 65, and you were already receiving Social Security retirement payments

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Life Insurance Effective January 1, 2022

An administrative change took place for the organization's life insurance benefits. Under Portability and Conversion, the plan is modified as follows: (changes bolded)

Shortly after benefits terminate, you will receive a mailing from Securian to your home mailing address on file with us that outlines your portability and conversion options, with associated costs. It is your responsibility to review this information and respond within required timeframes as well as ensuring we have your correct home mailing address on file. **It is also your responsibility to contact Securian if you wish to pursue portability or conversion of your group life insurance policy but did not receive an offer to continue coverage. You must contact them within 30 days following your termination of benefits to make a request for a portability/conversion offer. Securian's phone number is 866-293-6047.**

Long-term Disability Effective January 1, 2022

An administrative change took place for the organization's long-term disability insurance benefits. Under Conversion, the plan is modified as follows: (changes bolded)

If your long-term disability insurance is terminated due to your employment status changing (such as going from a benefits-eligible to non-benefits-eligible position) or your employment ending, you will receive information from Cigna, after your coverage has ended, to allow you to continue coverage. **It is your responsibility to contact New York Life/Cigna if you wish to pursue conversion of your group long-term disability policy but did not receive an offer to continue coverage. You must contact them within 30 days following your termination of benefits to make a request for a conversion offer. New York Life's phone number is 877-827-6890.**

The medical plan will cover the initial office visit reporting the system of a sexual dysfunction if it results in the identification of another medical condition not previously diagnosed.

The medical benefits exclusions is amended to read:

- Services related to the diagnosis, beyond the initial office visit, and treatment of sexual dysfunctions or addiction.

Glossary

Allowable charge

The medical plan definitions are updated effective January 1, 2022 with reimbursement fee schedules and in accordance with provisions of the Federal No Surprises Act:

When services are provided by an out-of-network provider/facility, the allowable charge is based upon a percentage of the Centers for Medicare and Medicaid Services (Medicare) fee schedules as set forth below:

Lab/Durable Medical Equipment (DME) 110%; Professional 150% - 160%; Facility 170% - 180%. For services in which a Medicare rate is not available, 47% of billed charges is the allowable charge.

Emergency Care:

According to applicable law, emergency services received from **out-of-network providers** at **in-network** facilities, the cost-sharing for these services will be the same as if the services were provided from an in-network provider and facility under the plan. Non-contracted ground ambulances are always paid based on billed charges.

Participants are not responsible for charges received from out-of-network providers above the allowed amounts, in addition to any in-network deductible, copayments or coinsurance that may apply. The allowable amount from which cost sharing will be calculated will be based upon the lesser of the qualifying payment amount (as defined under the Federal No Surprises Act) or the billed amount.

Air Ambulance:

Consistent with the requirements of the Federal No Surprises Act, the cost-sharing for **out-of-network** air ambulance services shall be the same as if the services were provided by an **in-network provider** under the plan. The cost sharing amount shall be counted towards the in-network deductible, if any, and any in-network out of pocket maximum amount under the plan. The allowable amount from which cost sharing will be calculated will be based upon the lesser of the qualifying payment amount (as defined under the Federal No Surprises Act) or the billed amount.

Allowable charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Delete: allowable charges will never be less than negotiated fees.

Effective January 1, 2022, the Plan will comply with federally mandated protections in the event of surprise medical bills under the No Surprises Act. The following explains your rights, protections and includes contact information to file a complaint.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you

may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Labor or your medical vendor. The medical vendor will post their version of this notice as well.

Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the DOL's website (***www.dol.gov/ebsa***) for more information about your rights under federal law.

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Effective April 1, 2022

A benefits administration change by Providence Health Plan as the pharmacy benefits manager applies to certain specialty medications under the HRA medical and EPO (Oregon) medical prescription drug benefit plans.

The change is as follows:

Medical - HRA Medical Plan and EPO (Oregon) Medical Plan
Providence Health Plan has partnered with HealthSmart's Smart Rx Assist program to administer a copayment maximizer program for certain specialty medications covered under the prescription drug benefit.

When a financial assistance program is available from a prescription drug manufacturer, health plan participants taking the medication are required to participate in the Smart Rx Assist program to receive a $0 cost share for the specified medication. Failure to complete the enrollment process for participation will result in a higher specialty medication copayment/coinsurance, which can exceed the regular plan benefit cost shares.

Because out-of-pocket costs associated with this program are $0 for the plan participant, the manufacturer-funded patient assistance does not apply to out-of-pocket deductibles or maximums as those costs are not the responsibility of the plan participants.

The list of specialty medications subject to the Smart Rx Assist program is available at **Providence Health & Services Caregivers |Providence Health Plan** or you can call Smart Rx Assist at 833-798-6732.

For specialty medications not subject to this program, regular plan benefits will apply.