Providence
Health Assurance

MEDICARE SUPPLEMENT POLICY

FOR PROVIDENCE MEDICARE SUPPLEMENT (MEDIGAP) PLAN A

If you need help understanding the terms in this document, please refer to the "Definitions" section, or contact Customer Service by dialing (971) 345-4013 or 1-888-231-9287, if you are hearing impaired and using a TTY device, please call 711. Office hours are Monday through Friday, 8 a.m. to 5 p.m.

30-DAY RIGHT TO EXAMINE YOUR POLICY

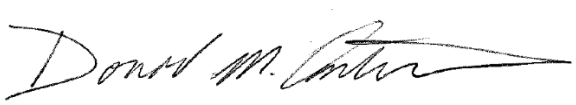
If you decide you do not want to purchase this policy for any reason, you may notify us within 30 days after delivery and your insurance will be deemed void from its effective date and premium payments received will be returned to you.

Any change in premium is subject to prior approval by the Oregon Department of Consumer and Business Services and will apply to all Members of the same age category insured under this policy.

Medicare may, from time to time, change its Deductible and Copayment amounts. When this happens, we will automatically cover the charged amounts that are eligible for benefits. Benefits and cost vary depending upon the Plan selected. The policy coverage shall be guaranteed renewable, but Providence Health Assurance reserves the right to change premiums and any renewal premium increases. On each annual anniversary of your Plan Renewal Date, premiums will increase due to the increase in your age.

The renewal premium for this policy will be the renewal premium then in effect for your attained age. The premium may also change for other reasons. Any change in premium will apply to all covered persons in your same class based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

NOTICE TO BUYER: This policy may not cover all your medical expenses. Please carefully review all policy limitations.



Don Antonucci, Chief Executive Officer
Providence Health Plan
P.O. Box 4327
Portland, OR 97208-4327

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PROVIDENCE HEALTH ASSURANCE QUICK REFERENCE GUIDE

Resource	Contact Information
Customer Service Available Monday–Friday, 8 a.m. to 5 p.m. (Pacific Time)	(971) 345-4013 (local) 888-231-9287 (toll-free) 711 (TTY) ProvidenceMedicareSupplement.com
Providence Nurse Advice Line	(503) 215-6755 (local) 888-989-3192 (toll-free)
Medicare Information	https://www.medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf
Medigap / Medicare Supplement Information	https://www.medicare.gov/media/9486
Providence Health Assurance Medicare Supplement Application Form	ProvidenceMedicareSupplement.com
Providence Health Assurance Medicare Supplement Application Form mailing address	Providence Medicare Supplement Enrollment PO Box 14590 Salem, OR 97309
Pay by mail	Monthly Premium Payment Options Providence Medicare Supplement PO Box 4900 Unit 44 Portland, OR 97208-4900

WELCOME TO PROVIDENCE HEALTH ASSURANCE

Thank you for choosing Providence Health Assurance as your Medicare Supplement insurer. We are here to help you with your health insurance needs and we welcome any questions you may have about your policy or coverage.

This policy explains your Providence Medicare Supplement benefits, exclusions, limitations, and the terms and conditions of coverage. This policy consists of this document, the Outline of Medicare Supplement Coverage, and any attached endorsements or amendments.

Important terms used in this policy appear throughout this document and are capitalized for easier identification. The definitions for these terms appear at the end of this document in the Definitions section.

We want you to understand how to use your Providence Medicare Supplement Plan benefits and to be satisfied with your health plan coverage. Customer Service is available to assist you in understanding your benefits and resolving any problems you may have, including:

- Specific benefit or claim questions
- Address and name changes
- Enrollment issues
- Questions or concerns about your health care or service

For assistance, please call us Monday through Friday between 8:00 a.m. and 5:00 p.m. (Pacific Time)

- (971) 345-4013
- 888-231-9287
- For hearing impaired and using a TTY device, please call 711

Please submit written communication to:
Providence Medicare Supplement
PO Box 14590
Salem, OR 97309

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Assurance, you should know what to expect from us, as well as what we ask from you. Nobody knows more about your health than you and your doctor. We take responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. We want you to have a positive experience with Providence Health Assurance, and we are ready to help in any way.

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Assurance, our providers, and the benefits and services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care Provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care Provider or through written advance directives.
- Have access to medical services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Assurance.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Assurance's Member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in, and the terms of, your policy. We will have no liability whatsoever for your misunderstanding, misinterpretation, or ignorance of the terms, provisions, and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact customer service. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your Physician or Provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Assurance and your Physicians or Providers need to provide care.

- Do your part to prevent disease and Injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your Physicians or Providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical services.
- Let us know if you have concerns or if you feel that any of your rights are being compromised, so that we can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of services provided or Appeal a Providence Health Assurance decision.
- Notify Customer Service if your address changes.

Providence Health Assurance has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care services.
- Enable you to see physicians or Providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate and up-to-date information about Providence Health Assurance.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Assurance policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

YOUR MEMBER ID CARD

Every Providence Medicare Supplement Plan Member receives a Member ID card. Your Member ID card lists information about your health plan coverage, including:

- Your Member number
- Important phone numbers

The Member ID card is issued by Providence Health Assurance for Member identification purposes only. It does not confer any right to services or other benefits under this Medicare Supplement Policy.

When scheduling an appointment or receiving health services, identify yourself as a Providence Medicare Supplement Plan Member, and present your Member ID card.

Please keep your Member ID card with you and use it when you:

- Visit your health care Provider or facility
- Call or correspond with Customer Service
- Call Providence RN medical advice line
- Receive immediate, urgent, or Emergency Care services

VALUE-ADDED SERVICES

In addition to your Medicare benefits, Providence Health Assurance offers optional value-added services that are not a part of your Medicare benefits. Our value-added services include access to a nurse advice line, One Pass's fitness program at no cost to you, and discounts on hearing aids (TruHearing) and meal delivery (Mom's Meals).

PROVIDENCE NURSE ADVICE LINE

(503) 215-6755 (local); 888-989-3192 (toll-free); TTY 711

The Providence nurse advice line is a free medical advice line for Providence Health Assurance Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

Members often call the Providence nurse advice line when they have questions about how to treat flus, colds, or backaches. After a brief recorded message, a registered nurse will be available to assist you.

Please have your Member ID card available when you call.

FITNESS PROGRAM

Upon enrollment, all Members have access to the One Pass fitness program at no cost. The program offers a single membership at one of over 26,000 gyms and boutique fitness studios, with the ability to change locations anytime. You also have access to live virtual classes and social activities within local communities. Call 1-877-504-6830 (TTY: 711) or visit www.YourOnePass.com to learn more.

This program does not cover expenses for supplements, over-the-counter products, fees for fitness devices, or other health-related products recommended by a fitness center or health and exercise plan.

If this benefit ends, we will send a letter notifying Members at least 30 days prior to its termination.

HEARING AID DISCOUNT

Upon enrollment, all Members can save on hearing exams and get discounts on over 200 hearing aid models from top hearing aid manufacturers through our partner TruHearing. Prices and discounts vary by product. TruHearing also offers a 60-day trial period, one year of follow-up visits,

and 80 free batteries per non-rechargeable hearing aid. Call 1-855-204-8584 or visit TruHearing.com/Providence-HS to learn more.

If this benefit ends, we will send a letter notifying Members at least 30 days prior to its termination.

MOM'S MEALS DISCOUNT

Upon enrollment, Mom's Meals offers all Members discounts on nutritionally balanced meals delivered direct to their home. Mom's Meals delivers refrigerated meals that are ready to eat after heating for two minutes. Members pay $7.99 per meal or $8.99 per meal for Pureed, Renal, and Gluten Free (shipping included). Orders are shipped in coolers of 10, 14, or 21 meals. Place orders at 1-877-347-3438 or online at momsmeals.com/ProvMs and use promotion code ProvMS.

If this benefit ends, we will send a letter notifying Members at least 30 days prior to its termination.

HOUSEHOLD PREMIUM DISCOUNT

You may be eligible for a discount of up to 20% off your monthly premium if you (1) are married or live with a domestic partner or adult at the same physical address, or (2) have lived with at least one, but no more than three, other adults 18 years of age or older in the last 12 months at the same physical address. The household discount is not available to those living in a one-person household, or in an assisted living facility.

DISCLOSURES

The following is a brief outline of key provisions of your Medicare Supplement Policy.

- Some capitalized terms have specific meanings in this policy. Please see the Definitions section (page 23).
- In this document, Providence Health Assurance is referred to as "we," "us" or "our." Members enrolled under this policy are referred to as "you" or "your".
- In this document, your Medicare Supplement Policy is referred to as "Medicare Supplement" or "Supplement."
- If after examining this policy you are not satisfied with it for any reason, you may cancel this policy within 30 days of receipt. Your decision to cancel this policy must be provided to us in writing within the 30-day period, and we will provide a full refund of your premium and consider the policy void and never effective.
- Coverage under this Medicare Supplement Plan is available 24 hours a day, seven days a week and during periods of domestic travel (see note below).
- Enrolled policyholders must reside in our Service Area, which is all counties within the state of Oregon.
- The Contract for this Medicare Supplement Plan includes this document (policy), the Outline of Coverage, any endorsements or amendments that accompany those documents,

and those policies maintained by Providence Health Assurance which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) endorsements and amendments, (2) Medicare Supplement Policy, (3) Outline of Coverage, and (4) applicable Providence Health Assurance policies.

Note: Except in limited situations, Medicare does not pay for health care services you receive outside the U.S.

ELIGIBILITY

Eligibility for Medicare Supplement coverage is determined by the Centers for Medicare and Medicaid Services (CMS)—the federal Agency who oversees Medicare. Coverage is available to individuals who:

- Are enrolled in Medicare Part A (Hospital) and Part B (Medical) by reason of age (65 or older) or disability;
- Permanently reside in the United States;
- Currently reside in the state of Oregon at the time of submitting the enrollment form; and
- Individuals who become eligible for Medicare due to age, disability, or end-stage renal disease.

Members who do not maintain eligibility as specified above are not eligible for coverage under this Plan.

ENROLLMENT AND DISENROLLMENT

All eligible Participants must enroll on enrollment forms or enrollment systems provided or approved by Providence Health Assurance. Application/enrollment information should be received by Providence Health Assurance at least 30 days prior to the requested Effective Date of Coverage. Providence Health Assurance cannot complete an enrollment unless both of the following are true:

- Providence Health Assurance receives a fully complete application/enrollment form that is signed and dated by the prospective enrollee; and
- The date of signature is prior to the requested Effective Date of Coverage.

Members wishing to disenroll from this Plan must submit a written disenrollment request to Providence Health Assurance. Disenrollment will take effect as specified in the disenrollment confirmation letter that Providence Health Assurance provides to the Member.

SELECTING A PROVIDER

This Plan is an open-network Plan, which means that Members may obtain services from Medicare-approved Physicians/Providers and facilities of their choice. Additional details can be found below in the Claims Administration and Payment section of this document.

GENERAL EXCLUSIONS

This Medicare Supplement Plan will not provide benefits for:

Benefits available from other sources: To the extent that a Member can recover any expenses through a federal, state, county or municipal law or private medical insurance. This exclusion does not apply to Medicaid.

Care provided without charge: For stays, care, or visits for which no charge would be made to a Member in absence of insurance.

Dental care: Except for those services covered under Medicare.
Duplicate benefits: In no event will medical payment under this Plan duplicate any amounts payable under Medicare.

Eyeglasses and hearing aids: Including the purchase of eyeglasses or hearing aids, or the examination for the prescribing, fitting, or changing of eyeglasses or hearing aids, unless determined eligible by Medicare.

Home recovery care: Such as short term at home assistance provided by a home health aide, homemaker, personal care aide, or nurse for activities of daily living. Activities of daily living include but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Outpatient prescription drugs and medicines: With or without a prescription. This exclusion does not apply to drugs and medical supplies and devices that are covered under Part A or Part B of Medicare.

Personal service items: Such as TVs, newspapers, telephones, or guest meals.

Preventive medical care: All preventive medical care unless such care is covered under Part B of Medicare.

Private nurses: Services of special private duty nurses are excluded unless such services are covered under Part B of Medicare.

Psychiatric Care which exceeds Medicare's psychiatric lifetime limitations or maximums: The Psychiatric Care benefit is administered in accordance with Medicare's rules and regulations, which state Medicare pays up to 190 days of inpatient care in a Medicare-certified psychiatric facility during your lifetime.

Services and supplies not recognized as a claim under Medicare.

Services provided before the effective date or after the termination date: Part A or Part B Medicare Eligible Expenses that began before the Member's Effective Date of Coverage or after the termination date under the policy are not covered.

Services received from ineligible institutions: Such as services provided and billed by boarding homes, intermediate care facilities, homes for the aged, homes for drug addicts or alcoholics, schools or halfway houses, or services by any members of their staff.

Services received in government hospitals: Including any services or supplies furnished by the Veterans Administration or by any institution that is owned or run by a federal, state, county, or municipal government, unless payment of the charge under the policy is required by law.

CLAIMS ADMINISTRATION AND PAYMENT

SUBMITTING CLAIMS TO MEDICARE FIRST

Before Providence Health Assurance can pay any benefits for expenses covered under this Plan the Member's treating Provider must file a claim for those expenses with Medicare. Typically, these claims are submitted to us from Providers on your behalf and you are not requested to initiate the process. Providence Health Assurance must receive confirmation from the Medicare carrier or intermediary that details the Medicare Eligible Expenses on a Medicare Summary Notice. Only those charges determined by Medicare to be Medicare Eligible Expenses will be covered.

Providence Health Assurance
Attention: Claims Department
PO Box 14590
Salem, OR 97309

TIME LIMITS FOR SUBMITTING CLAIMS

Providence Health Assurance recommends that Members submit their claims, along with the EOB, within 90 days of service or as soon as reasonably possible. However, claims, along with the EOB, can be submitted up to 12 months after the date of service. Providence Health Assurance will make no payments for claims received more than 12 months after the date of service, with the following exceptions consistent with Medicare timely filing guidelines:

- Administrative error;
- Retroactive Medicare entitlement involving state Medicaid agencies;
- Retroactive disenrollment from a Medicare Advantage Plan (MA); or
- Retroactive disenrollment from a program of All-inclusive Care of the Elderly (PACE).

If a Member is billed directly and pays for benefits which are covered by this Plan, reimbursement from the Plan will be made upon the Member's written notice to the Plan of the payment.

Claim forms are available at providencehealthplan.com/forms.

PAYMENT OF CLAIMS

All benefits payable under this Plan, except for benefits for Emergency Care in a foreign country, will be paid to whoever received the Medicare payment.

The service Provider must accept the Plan's payment as payment in full and may not bill the Member for any amounts over the Medicare Deductible and Coinsurance. There is an exception for some Providers, such as specialists who are allowed to bill 15 percent above Medicare's Approved Amount for medical procedures. The 15 percent difference between the Medicare-Approved Amount and the higher charge is also known as a Limiting Charge.

Benefits for emergency medical care in a foreign country are payable to the Member in United States currency in an amount based on the bank transfer exchange rate in effect on the day the services were received. For more information on emergency medical care in a foreign country, please refer to the "Emergency Medical Care in a Foreign Country" section of this document.

Providers must accept the issuer's payment as payment in full and may not bill the insured for any balance.

Upon exhaustion of the Medicare hospital inpatient coverage, including the Lifetime Reserve Days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment, which may be prescribed herein and effective at the time of payment. If no such designation or provision is in effect, such indemnity shall be payable to the estate of the insured.

Indemnities payable under this policy will be paid immediately upon receipt of written proof of loss. Losses for which this policy provides periodic payment will be paid on a biweekly schedule.

CLAIMS PAID IN ERROR

If Providence Health Assurance pays a claim in error, Providence Health Assurance has the right to recover the payment from the party or facility paid.

APPEALS

Please refer to the Grievance and Appeals section of this document for information on appealing claim payments or claim denials.

PROBLEM RESOLUTION

INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Assurance share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or services by Providers, please ask for our help. Your Customer Service representative is available to provide information and assistance. You may call us at the phone number and address listed on your

Member ID card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us for help with any special needs you may have.

FORMAL PROBLEM RESOLUTION

If a Member has a Grievance (complaint) about Providence Health Assurance (for example, dissatisfaction with Providence Health Assurance's customer service), he/she has the right to file a Grievance in writing. If Providence Health Assurance denies all or part of a claim, a Member has the right to file an Appeal. A formal complaint, Grievance or Appeal must be submitted in writing. All quality-of-care issues must also be formally submitted in writing.

Filing a Grievance

Members should file a Grievance within 180 days of the occurrence that led to the Grievance and should include all the relevant information, including the date of the incident, the names of the individuals involved, and the specific circumstances.

Providence Health Assurance will respond to a Grievance, in writing, within 30 days.

Filing an Appeal (Overview)

If Providence Health Assurance denies all or part of a claim that a Member believes is a covered service under this Plan, the Member has the right to file an Appeal. Appeals must be submitted within 180 days of the date on the payment or denial letter to qualify for review. This timeline may be extended if Providence Health Assurance receives proof of the Member's legal incapacitation. Any additional information that was not available at the time the claim was reviewed should be included with the Appeal.

Providence Health Assurance will send a written notice of the Appeal decision within 60 days. If a more complete review is necessary, Providence Health Assurance may take up to 120 days, but Providence Health Assurance will notify the Member of that circumstance within 60 days.

How to Submit Grievances and Claims Appeals

Members may contact our Customer Service Team at (971) 345-4013 or 888-231-9287. For hearing impaired users using a TTY device, please call 711. Formal Grievances and written Appeals should be sent to:
Providence Health Assurance
Appeals and Grievance Department
PO Box 4158
Portland, Oregon 97208-4158

In addition, Members may fax a Grievance or Appeal to (503) 574-8757 or 1-800-396-4778.

External Review

If your Appeal involves (a) medically necessary treatment, (b) experimental investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a

course of treatment is delivered in an appropriate setting at an appropriate level of care, you may waive your right to internal Appeal and request an external review by an Independent Review Organization. Your request for external review must be made to Providence Health Assurance in writing within 180 days of the date on the Medicare Summary Notice, or that decision will become final.

Assistance with your Grievance or Appeal

You may, at any time during the Grievance and Appeal process, seek assistance from the Oregon Division of Financial Regulation with your concerns regarding our decisions and benefits. You may contact the Oregon Division of Financial Regulation at:

Oregon Division of Financial Regulation Consumer Protection Unit
PO Box 14480
Salem, OR 97309-0405

(503) 947-7984 (phone)
888-877-4894 (toll-free)
(503) 378-4351 (fax)

DFR.InsuranceHelp@oregon.gov (e-mail) https://dfr.oregon.gov (website)

Members may also seek assistance from Senior Health Insurance Benefits Assistance (SHIBA) at the Oregon Insurance Division by calling 1-800-722-4134 or by contacting them through their website at healthcare.oregon.gov/shiba/.

For Grievances that involve Medicare coverage itself, Members should call Medicare directly at 1-800-MEDICARE (1-800-633-4227).

SUSPENSION OF MEMBER COVERAGE

If you become eligible for Medicaid after purchasing this policy, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.

TERMINATION OF MEMBER COVERAGE

Termination of Member coverage under this policy will occur on the earliest of the following dates:

- The end of the period for which required premium was due to Providence Health Assurance and is not received by Providence Health Assurance;
- The last day of the month in which a Member does not maintain their enrollment under both Parts A and B of Medicare;
- The end of the month in which a Member requests termination of their coverage to be

effective;

- The date on which any fraudulent information is provided by a Member that affects their eligibility or benefits under this policy; or
- For a deceased Member, after documentation has been submitted, the date of death.

Termination of a Medicare Supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force.

After two years from the date of policy issue, no misstatements except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or deny a claim.

This policy shall provide the opportunity for suspension at the request of the policyholder or certificate holder for a period not to exceed 24 months.

Beginning 30 days prior to a person's birthday, and for 30 days after their birthday, a Medicare Supplement policy owner may cancel their existing Medicare Supplement policy or certificate and purchase another Medicare Supplement policy or certificate with the same or lesser benefits to replace the existing policy or certificate.

PREMIUMS, RENEWAL, REVISION, RESCISSION, AND REINSTATEMENT

PREMIUMS

Premium Billing Information

Providence Health Assurance will provide a monthly premium billing statement to the policyholder listing the amount of premium due.

Changes in Premium Charges

The premium may be changed only in accordance with the following provisions:

- The premium is subject to change upon renewal of this policy for another plan year.
- If at any time during a plan year any federal or state law or any order or regulation of a federal or state agency mandates a modification of benefits under this policy, we may change the premium and/or covered services accordingly and you will be notified of this change in writing. The change in premium shall be effective on the effective date of the modification of benefits, as stated in the notice.

Premium Payment Due Date

The premium is due on the first of the month. If the policyholder does not pay the premium by the first of the month, the policy will be in a 60-day grace period (two billing cycles). We will mail two premium delinquency notices to the policyholder. If the policyholder does not pay the premium by the last day of the 60-day grace period, as specified in the notice, coverage will be terminated retroactively to the month you last paid in full, with no further notice to the policyholder. Failure to pay the premium includes making a partial payment of the amount due as premium. If we fail to send the premium delinquency notice specified above, we will continue the policy in effect,

without payment of premium, until we provide such notice.

RENEWAL AND REVISION

This policy is guaranteed renewable and will not be terminated due to claims experience, health status, or length of time in force. Once you are enrolled in a Medicare Supplement Plan, it renews every year as long as you pay your premium, and the Plan is available.

We may revise this policy upon renewal with prior approval from the Oregon Insurance Division and written notice to you at least 30 days prior to the start of a new plan year.

Your payment of premium constitutes acceptance of any revisions to the provisions of this policy that may occur at renewal or outside of renewal as permissible by applicable federal or state law.

The receipt of Medicare Part D benefits will not be considered in determining a continuous loss. Per CMS regulations, Medicare Supplement policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Supplement policy, you can keep it. If you join a Medicare drug plan, Providence Health Assurance must remove the prescription drug coverage under your Medigap policy and adjust your premiums.

RESCISSION (CONTRACT CANCELLATION)

Disenrollment from this Plan Policy

Disenrollment means that your coverage under this policy is terminated by us because you have engaged in fraudulent or dishonest behavior, such as:

- Filing false claims with us;
- Allowing a non-Member to use your Member ID card to obtain services; or
- Providing false information on your application for coverage or on any subsequent form requesting a change to your coverage.

Termination and Rescission of Coverage Due to Fraud or Abuse

Your coverage under this policy may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you. If coverage is rescinded, Providence Health Assurance will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered dependents the benefits paid as a result of such wrongful activity. We will provide all affected Plan Participants with a 30-day notice before rescinding your coverage.

Non-Liability After Termination

Upon termination of this policy, we shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another plan with Providence Health Assurance.

Notice of Creditable Coverage

We will provide, upon request, written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this policy; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

REINSTATEMENT

If the renewal premium has not been paid within the time granted and Providence Health Assurance or an authorized agent accepts a subsequent premium, Providence Health Assurance shall reinstate the policy.

FURTHER CONDITIONS OF THIS CONTRACT

EFFECT OF CHANGE OF PLAN

If a Member switches to coverage under this Plan from any other Medicare Supplement Plan, no benefits will be paid under this Plan for any stay or care to the extent that benefits are paid under the prior plan.

NOTICE OF PRIOR COVERAGE

Providence Health Assurance will provide written certification of a Member's period of creditable coverage when the Member ceases to be covered under this Plan or when a Member requests a Notice of Creditable Coverage within 24 months after coverage ceases under this Plan.

INDUCEMENTS NOT SPECIFIED IN POLICY

Except as otherwise expressly provided by the Insurance Code, no person shall permit, offer to make, or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the policy issued thereon.

RELEASING NECESSARY INFORMATION

Hospitals, Skilled Nursing Facilities, Physicians, Providers, Medicare intermediaries, other carriers, or other agencies often have information Providence Health Assurance needs to determine a Member's coverage or benefits. By enrolling for coverage in this Medicare Supplement Plan, Members authorize Providence Health Assurance to obtain such information. Providence Health Assurance will safeguard the confidentiality of these records.

PRIVACY OF MEMBER INFORMATION

At Providence Health Assurance, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information (commonly called PHI or your personal information), including in electronic format.

When we use the term “personal information” we mean information that identifies you as an individual such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. Providence Health Assurance maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain copies of their medical records from the Provider. Call your Physician’s or Provider’s office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices/ or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your Authorized Representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence Health Assurance’s policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/.

The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits but does apply to attorneys who represent a medical service Provider whose services are a part of the claim in issue. At Providence Health Assurance, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Assurance takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. We use PHI and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways we may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to inform you about alternative medical treatments and programs or about health-related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about “healthy living” alternatives, such as smoking cessation or weight loss programs).

- We make every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need-to-know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, we have procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Providers in our network contain confidentiality provisions that require Providers treat your PHI with the same care. Providers you may use who are outside of Providence Health Assurance's network are required to adhere to the same rules.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your Physician's or Provider's office to ask how to schedule a visit for this purpose.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at www.ProvidenceHealthPlan.com/privacy or by calling Customer Service.

FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to us to be true, correct, and complete. If a Member willfully fails to provide information required to be provided or knowingly provides incorrect or incomplete information, then plan coverage for the affected Member(s) may be terminated as described in the "Termination of Member Coverage" section.

MEMBER ID CARD

The Member ID card is issued by Providence Health Assurance for Member identification purposes only. It does not confer any right to services or other benefits under this Plan.

NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is non-transferable.

TIME LIMIT ON CERTAIN DEFENSES

After a Member's coverage under this Plan has been in effect for two years, Providence Health Assurance may not cancel, refuse to renew, or void a Member's coverage for a material misrepresentation or omission in the application, unless it was fraudulent.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

No Member shall bring any action at law or in equity to recover benefits prior to receiving a final decision on an Appeal, as described in the Grievance and Appeal Rights section of this document. Member's sole right of Appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this policy.

Further, no such action shall be brought later than three years after receiving a final decision on an Appeal.

PHYSICAL EXAMINATION AND AUTOPSY

Providence Health Assurance, at its own expense, shall have the right and opportunity to order an examination of any Member when and as often as Providence Health Assurance may reasonably require during the pendency of any claim covered by the policy. Providence Health Assurance also has the right to order an autopsy in the case of death if not forbidden by law.

PRE-EXISTING CONDITION LIMITATIONS

This policy does not pay benefits for loss resulting from a pre-existing condition occurring within six months after the Effective Date of Coverage. A pre-existing condition is any Injury, sickness, or disease for which the insured has received, or has had recommended, medical advice or treatment during the six months before the Effective Date of Coverage. Please note that pre-existing conditions will be covered after six months from the Effective Date of Coverage. This exclusion does not apply to loss occurring more than six months after the Effective Date of Coverage.

If you apply for this policy during the six-month period beginning with the first day of the first month in which you are eligible, and you had a Continuous Period of Creditable Coverage of at least six months as of the date you apply, the pre-existing conditions limitation will not apply to you.

If you apply for this policy during the six-month period beginning with the first day of the first month in which you are eligible, and as of the date you apply you had a Continuous Period of Creditable Coverage of less than six months, the pre-existing conditions limitation will be reduced by the aggregate of the period of Creditable Coverage applicable as of your enrollment date.

If this policy is issued to replace another Medicare Supplement policy or as a result of certain situations involving health coverage changes, the pre-existing conditions exclusion will not be applied. Some of these situations include loss of your policyholder's group coverage and termination of a Medicare Advantage Plan, including termination of coverage because you moved out of the Plan's service area or the insurance company that provided you Medicare Supplement coverage went out of business or committed fraud.

EXCLUSIONS

We will not pay for:

- Losses incurred while your policy is not in force;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- That portion of any loss incurred which is paid for by Medicare;
- Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Losses payable under any other Medicare Supplement insurance policy or certificate; or
- Losses payable under any other insurance which paid benefits for the same loss on an expense incurred basis.

PROOF OF LOSS

Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

ELIGIBILITY DETAILS

"Eligible persons" is defined as one of the following per State of Oregon regulations:

(a) An individual enrolled under an employee welfare benefit plan, an individual health benefit plan, a state Medicaid plan as described in Title XIX of the Social Security Act or Tricare as described in Title XVIII of the Social Security Act that provides health benefits that supplement the benefits under Medicare and the plan terminates or ceases to provide all such supplemental health benefits; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or ceases to provide all health benefits to the individual.

(b) An individual enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the circumstances apply under OAR 836-052-0142(2)(b), or the individual is 65 years of age or older and is enrolled with a Program of All Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described in this subsection that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan.

(c) An individual enrolled with an eligible organization defined in OAR 836-052-0142(2)(c)(A) and (B).

(d) An individual enrolled under a Medicare supplement policy and the enrollment ceases due to circumstances described in OAR 836-052-0142(2)(d).

(e) An individual enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls under circumstances prescribed in OAR 836-052-0142(2)(e)(A) and (B).

(f) An individual, within six months after becoming enrolled in Part B of Medicare, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

g) An individual enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence in Medicare Part D along with the application for a policy described in OAR 836-052-0142(5)(d).

DEFINITIONS

The following are definitions of important terms used in this Certificate of Coverage and appear throughout this document.

Accident: An Injury sustained by a Member that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.

Adverse Benefit Determination:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of Injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise covered services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Approved Amount: The amount Medicare determines to be reasonable for the service that is covered. It may be less than the actual charge. For many services, including Physician services, the Approved Amount is taken from a fee schedule that assigns a dollar value to all Medicare-covered services that are paid under that fee schedule.

Appeal: A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Assignment: An arrangement whereby a Physician, health care Provider, Hospital or Skilled Nursing Facility, or other medical supplier agrees to accept the Medicare Approved Amount as full payment for services and supplies covered under Part B and may not bill the Member for any more than the Medicare Deductible and Coinsurance. Medicare usually pays 80 percent of the Approved Amount directly to the Physician or supplier after the beneficiary meets the Deductible. The beneficiary pays the other 20 percent.

Authorized Representative: An individual who by law or by the authorization of a Member may act on behalf of the Member.

Benefit Period: The period used to measure a Medicare beneficiary's use of Hospital and Skilled Nursing Facility services covered by Medicare. A Benefit Period begins the day a Member is hospitalized. It ends after the Member has been out of the Hospital or other facility that primarily provides skilled nursing or rehabilitation services (or, if in the latter type of facility, has not received skilled care there) for 60 days in a row. If a Member is hospitalized after 60 days, a new Benefit Period begins, most Medicare Part A benefits are renewed, and the Member must pay a

new Inpatient Hospital Deductible. There is no limit to the number of Benefit Periods a Member can have.

Coinsurance: An amount a Member may be required to pay as a Member's share of the cost for a medical service or supply after Member pays any Deductible. Coinsurance is usually a percentage, for example, 20 percent.

Concurrent Care: An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Convalescent Nursing Home: A facility with medically trained staff who deliver short-term care. The people receiving convalescent care are getting temporary care to recover from some sort of set-back, such as an Injury, illness, or operation.

Copayment: An amount a Member may be required to pay as the Member's share of the cost for a medical service or supply, like a doctor's visit or Hospital outpatient visit. A Copayment is usually a set amount, rather than a percentage. For example, a Member might pay $10 or $20 for a doctor's visit.

Cost-Sharing: An amount a Member may be required to pay as a Member's share of the cost for a medical service or supply, like a doctor's visit or Hospital outpatient visit. This amount can include Copayments, Coinsurance, and/or Deductible.

Deductible: The amount a Member must pay for health care before Original Medicare or the Plan begins to pay.

Effective Date of Coverage: The date upon which coverage under the policy commences for a Member.

Emergency Care: Care that is needed immediately for an Injury, illness, or condition of sudden or unexpected onset that would be deemed, under appropriate medical standards, to carry substantial risk of serious medical complication or permanent damage to a Member if care or services are withheld.

Grievance: A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery, or quality of a health care service;

- Claims payment, handling, or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Assurance.

Guarantee Issue Rights (also called Medigap protections): Rights you have in certain situations when insurance companies must offer you certain Medigap policies. In these situations, an insurance company:

- Must sell you a Medigap policy
- Must cover all your pre-existing health conditions
- Cannot charge you more for a Medigap policy because of past or present health problems

In most cases, you have a Guaranteed Issue Right when you have other health coverage that changes in some way, like when you lose the other health care coverage. In other cases, you have a "trial right" to try a Medicare Advantage Plan (Part C) and still buy a Medigap policy if you change your mind.

Health Care Expenses: Expenses associated with the delivery of health care services to a Member.

Hospital: A Medicare-approved institution that provides care for which Medicare pays hospital benefits.

Injury/Injuries: Bodily Injury caused by an Accident and resulting directly and independently of all other causes.

Lifetime Reserve Days: A lifetime reserve of 60 days for Medicare Part A inpatient Hospital care. These days must be used whenever more than 90 days of inpatient Hospital care are needed in a Benefit Period.

Limiting Charge: The maximum amount a Physician may charge a Medicare beneficiary for a covered Physician service if the Physician does not accept Assignment of Medicare claims. The limit is 15 percent above the fee schedule amount for non-participating Physicians. Limiting charge information appears on the Medicare Explanation of Benefits form or the Medicare Summary Notice (MSN).

Medicaid: A program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Disability Act.

Medicare: Parts A and B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare Eligible Expenses: Expenses covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Summary Notice (MSN): The form Medicare sends to a Member to show what action was taken on Member's Medicare claim.

Medicare Part A Inpatient Hospital Deductible: The amount normally due from a Medicare beneficiary upon first admission to a Hospital in each Benefit Period, before benefits are available under Part A of Medicare.

Member: An individual who is eligible for and properly enrolled in this Plan and is entitled to services under the policy.

Outline of Medicare Supplement Coverage: Document summarizing the Plan benefits.

Participant: A person who participates who is eligible to enroll in this Plan.

Physician/Provider: A licensed practitioner of the healing arts acting within the scope of their license.

Plan: The benefits that are provided under the policy.

Providence Health Assurance: The nonprofit corporation authorized as a health care service contractor in the state of Oregon that issues the contract.

Psychiatric Care: The treatment for any neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disorder or disease, and alcoholism and drug addiction.

Sickness: Illness or disease of a Member that manifests itself after the Effective Date of Coverage under this policy and while the coverage under this policy is in force.

Skilled Nursing Facility: Facility that provides skilled nursing care and is approved for payment by Medicare.