

- e. An entity newly formed from one or more of the organizations described above.

Yes No

If you selected Yes, please describe the newly formed organization and explain how the constituent or predecessor organizations meets one of the requirements in (a) through (d) above:

Please note: Applicant’s qualifications to apply will not be evaluated until after the Application due date.

7. Desired Service Area

County (List each desired County separately)	In your Application, will you request to serve less than the entire County?	If yes, what zip codes will be in your requested Service Area in this County?
Multnomah Washington Clackamas	No No No	N/A N/A N/A
Hood River Clatsop	No No	N/A N/A
Jackson	No	N/A

Please note: If Applicant requests to cover less than a full County, it will be required to provide additional information and its reasoning for the request in its Application. OHA will consider requests during Application evaluation and will determine whether to approve or reject the request based on criteria that include, but are not limited to, how the request better serves the goals of CCO 2.0 than serving the entire County at issue. These Applicant requests and subsequent OHA responses do not limit OHA in any way from requiring additional changes to an Applicant’s proposed Service Area based on OHA’s needs and the needs of its Members. OHA may require an Applicant to accept OHA’s additional Service Area request(s) as a condition of receiving an award or a Notice to Proceed as OHA and its Members’ needs warrant. Applicant’s requests for Service Area will not be evaluated until after the Application due date.

- 8. In Exhibit A, please provide an organization chart complying with the requirements of Attachment 6.
- 9. In Exhibit B, describe your current lines of health plan business in Oregon. Provide total covered lives for each line of business. (Provide separate figures for the following markets: Medicaid, other OHA, non-OHA state health plans, other state or local public sector, Medicare, other federal, Marketplace, other commercial insured, and commercial self-funded. Within each market identify numbers for benefit coverage types such as oral and comprehensive medical and identify numbers that are administrative-services-only as opposed to at-risk).

10. Applicant’s Good Faith Intentions

Applicant has a good faith intention to submit an Application and believes it has the resources to do so. If at any time prior to or upon the Application due date Applicant determines it will not submit an Application, Applicant will submit to OHA a notarized letter, withdrawing this letter of intent and briefly stating the reason for the withdrawal. If at any time prior to seven days before the Application due date Applicant determines it must change the provisions of this LOI other than the requested Service Area, Applicant will submit to OHA a notarized letter, changing this letter of intent and briefly stating the reason for the change.

11. Acknowledgements

Applicant acknowledges that this Letter of Intent is binding upon Applicant if it proceeds to submit an Application and continues through the RFA process without withdrawing its Application. Applicant also acknowledges that OHA will publicly post the information in this LOI prior to the Application submission date. To be considered for a CCO Contract, Applicant must submit all required document in the RFA by the applicable dates in Section 1.2 of the RFA.

Representatives of Applicant have read the RFA in its entirety. By submitting this Letter of Intent, Applicant acknowledges and agrees to be bound by RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims). Applicant also agrees to be bound by all the other provisions of the RFA, subject to Applicant’s protest rights as set forth in the RFA.

12. Signature

The signature must be notarized, as follows

I, Michael Cotton, being first duly sworn under oath, and representing Applicant, hereby depose and swear or affirms under penalty of perjury that:

- a. I am an officer of the Applicant,
- b. I have personal knowledge of this Letter of Intent and believe it to be accurate, and
- c. I have full authority from the Applicant to submit this Letter of Intent.

[Handwritten Signature]
Signature

Michael Cotton President, CEO
Printed Name and Title

1/31/19
Date

State of Oregon

) ss:

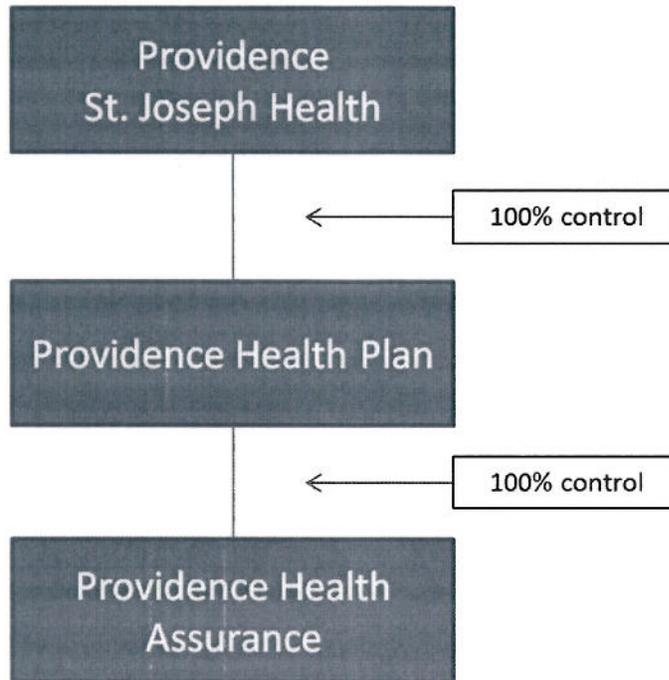
County of Multnomah

Signed and sworn to before me on 31st Jan 2019 (date) by Michael Cotton (Affiant’s name).

[Handwritten Signature]
Notary Public for the State of Oregon
My Commission Expires: 4/26/2021



EXHIBIT A: ORGANIZATION CHART
EXHIBIT B: OREGON HEALTH CARE BUSINESS



Providence Health Assurance serves 53,489 Oregon Health Plan (and Cover All Kids) beneficiaries as a physical health risk accepting entity of Health Share of Oregon Coordinated Care Organization. Providence Health Assurance also serves 54,311 Medicare beneficiaries through numerous Medicare Advantage and Part D contracts, including 951 dual eligible beneficiaries through a Dual Eligible Special Needs Plan.

Providence Health Plan, Providence Health Assurance's parent organization, serves Oregonians through fully insured large group, small group, and individual and family plans, as well as self-funded ASO plans including PEBB.

Total covered lives for Providence Health Plan broken down by each line of business are as follows:

ASO: 164,530 (including 95,481 covered lives for PEBB)

Large Group: 76,492

Small Group: 59,581

Individual: 72,635