CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS
Policy Session Worksheet

Presentation Date: October 6, 2020 **Approx. Start Time:** 2:00 PM **Approx. Length:** 30 Min

Presentation Title: Benefit Renewals for 2021

Department: Human Resources

Presenters: Kristi Durham, Benefits Manager

Other Invitees: Evelyn Minor-Lawrence, HR Director & Eric Sarha, Asst. HR Director

WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?
HR is seeking formal approval to renew benefit plans with providers for the 2021 calendar year, as well as approval of the 2021 non-represented cost sharing arrangement. Final plan documents are in the process of being prepared by providers. When completed, they will be reviewed and approved by County Counsel prior to submission to the Board for formal adoption at a future business meeting.

EXECUTIVE SUMMARY:
This policy session will update the Board on 2021 benefit plan renewals, including final plan design, language changes, rates, and benefit cost shares.

Medical/Vision:
There are approximately 1600 employees and early retirees enrolled in the General County medical plans. Due to a combination of plan changes the Benefits Review Committee (BRC) made in the 2017 plan year, and have continued to evaluate for the 2018-2020 renewal period, the 2021 Providence renewal rates increased 4.2%, and the 2021 Kaiser renewal rates decreased 2.5%.

The BRC chose not to make any plan design changes to the General County plans for the 2021 plan year, since the renewals were good overall, and the BRC felt it was important to take the county's financial picture and uncertainty around future COVID-19 claims into consideration. The BRC also felt it was important to provide stability in the county's benefits at this time, since the county and employees are already in a state of flux.

There are approximately 430 employees and early retirees enrolled in the Peace Officers Association (POA) medical plans. The 2021 Providence POA renewal rates increased 4.4%, and the 2021 Kaiser POA renewal rates increased 1.1%.

The POA union did not make any plan design changes to the POA medical plans for 2021.

The rate changes for the General County and POA medical and dental plans are associated with a variety of factors, including paid claims, stop loss credits and charges, historical cost trends and other fixed expenses.

The medical opt-out cash back amount is remaining the same for all groups in 2021.

Retiree/COBRA/Temporary Employee Medical:
The Clackamas County benefits division is proposing changes to the Providence and Kaiser $1000 deductible plans, which are more affordable medical plan options available to retired employees, COBRA participants and temporary employees who meet certain eligibility requirements. These plans are not available to regular employees.

FINANCIAL IMPLICATIONS (current year and ongoing):

Is this item in your current budget? ☒ YES ☐ NO

What is the cost?
The estimated fiscal impact for the 2021 plan year based on current enrollment is:

Medical/Vision:	$40,509,735.60 (increase of approximately $700,000 from 2020)
Dental:	$ 4,414,282.45 (increase of approximately $120,000 from 2020)
Opt-out cash back:	$ 486,960.00
Group Term Life:	$ 193,708.80
Disability (STD):	$ 265,708.00
Navia FSA Admin:	$ 37,327.20

What is the funding source? The funding is through contributions and fees paid by county departments, employees, retirees, COBRA beneficiaries, and other agencies contracting with Clackamas County for employee benefits administration.

STRATEGIC PLAN ALIGNMENT:

- How does this item align with your Department's Strategic Business Plan goals?

  The purpose of the Benefits program is to provide cost-effective, responsive and comprehensive benefit services to County departments, current, retired employees and their family members so they can better serve the residents of Clackamas County.

- How does this item align with the County's Performance Clackamas goals?

  Build trust through good government.

LEGAL/POLICY REQUIREMENTS:
Adherence to current labor contracts. Statutory requirement to include retirees in benefits risk pool and health plans.

PUBLIC/GOVERNMENTAL PARTICIPATION:
The County Benefits Review Committee met regularly throughout the 2021 renewal period in a series of meetings throughout spring and summer 2020. The Benefits Program, with the assistance of Public & Government Affairs (PGA), continues to revise the successful communication plan used in prior years. With the current pandemic environment, PGA and the Benefits team have been working together to create more virtual resources for employees as part of the upcoming open enrollment campaign. Benefits has continued to partner with PGA to maintain a strong communications presence regarding benefits.

OPTIONS:
1. Approve 2021 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve retiree/COBRA/temporary employee medical plan changes. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

2. Approve non-represented employee cost sharing arrangement with changes. Approve 2021 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia and move it forward for formal adoption at a future business meeting. Approve retiree/COBRA/temporary employee medical plan changes.

3. Do not approve 2021 renewals, retiree/COBRA/temporary employee medical plan changes and/or non-represented employee cost sharing arrangement.

RECOMMENDATION:

Staff recommends option 1: Approve 2021 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve retiree/COBRA/temporary employee medical plan changes. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

ATTACHMENTS:

1. 2021 Rate Chart (Exhibit A)
2. Clackamas County General County 2021 Draft Renewal Report (Exhibit B)
3. General County Providence 2021 Plan Language Changes (Exhibit C)
4. General County Kaiser 2021 Plan Language Changes (Exhibit D)
5. General County Delta Dental 2021 Plan Language Changes (Exhibit E)
6. Clackamas County POA 2021 Draft Renewal Report (Exhibit F)
7. POA Providence 2021 Plan Language Changes (Exhibit G)
8. POA Kaiser 2021 Plan Language Changes (Exhibit H)
9. POA Delta Dental 2021 Plan Language Changes (Exhibit I)
10. Retiree/COBRA/Temporary Employee Medical Proposal (Exhibit J)

SUBMITTED BY:

Division Director/Head Approval _______KD__________
Department Director/Head Approval ____EM-L__________
County Administrator Approval _________________

For information on this issue or copies of attachments, please contact Kristi Durham @ 503-742-5470

2021	NONREPRESENTED				REPRESENTED				PEACE OFFICERS			
MEDICAL												
	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family
Kaiser												
Employer	641.82	1,283.62	1,155.26	1,925.44	603.82	1,279.40	1,144.28	1,955.00	689.88	1,379.76	1,241.78	2,069.64
Employee	33.78	67.56	60.80	101.34	71.78	71.78	71.78	71.78	-	-	-	-
	675.60	1,351.18	1,216.06	2,026.78	675.60	1,351.18	1,216.06	2,026.78	689.88	1,379.76	1,241.78	2,069.64
Composite Equivalent				1,435.54				1,435.54				1,571.44
Employer							95%	1,363.76				
Employee								71.78				
Providence Personal Option/VSP Vision												
Employer	738.14	1,476.30	1,330.94	2,217.30	694.44	1,471.44	1,318.44	2,251.44	707.00	1,511.00	1,352.00	2,319.00
Employee	38.86	77.70	70.06	116.70	82.56	82.56	82.56	82.56	98.00	98.00	98.00	98.00
	777.00	1,554.00	1,401.00	2,334.00	777.00	1,554.00	1,401.00	2,334.00	805.00	1,609.00	1,450.00	2,417.00
Composite Equivalent				1,651.00				1,651.00				1,960.00
Employer							95%	1,568.44				1,862.00
Employee								82.56				98.00
Providence Open Option/VSP Vision												
Employer	814.14	1,627.34	1,467.74	2,442.44	650.00	1,506.00	1,338.00	2,364.00	756.70	1,615.70	1,446.70	2,477.70
Employee	42.86	85.66	77.26	128.56	207.00	207.00	207.00	207.00	104.30	104.30	104.30	104.30
	857.00	1,713.00	1,545.00	2,571.00	857.00	1,713.00	1,545.00	2,571.00	861.00	1,720.00	1,551.00	2,582.00
Composite Equivalent				2,011.00				2,011.00				2,086.00
Employer							90%	1,804.00				1,981.70
Employee								207.00				104.30
Medical Opt Out - Cash Back	83.00	164.00	148.00	247.00	185.00	185.00	185.00	185.00				
Medical Opt Out - HRA Contribution									176.00	176.00	176.00	176.00

	NONREPRESENTED				REPRESENTED				PEACE OFFICERS			
DENTAL												
Kaiser												
Employer	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Composite:				191.00				191.00				191.00
MODA Preventive												
Employer	84.00	169.00	121.00	207.00	84.00	169.00	121.00	207.00				
Employee	-	-	-	-	-	-	-	-				
	84.00	169.00	121.00	207.00	84.00	169.00	121.00	207.00				
Composite:				166.00				166.00				
MODA Incentive												-
Employer	96.00	194.00	136.00	233.00	96.00	194.00	136.00	233.00	74.00	146.00	105.00	177.00
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	96.00	194.00	136.00	233.00	96.00	194.00	136.00	233.00	74.00	146.00	105.00	177.00
Composite:				184.00				184.00				150.00
MODA 50%												
Employer	109.95	216.46	150.17	259.69	172.12	204.12	184.12	217.12				
Employee Cash Back	(48.00)	(94.00)	(65.00)	(113.00)	(87.00)	(87.00)	(87.00)	(87.00)				
FICA/PERS	(28.95)	(57.46)	(40.17)	(68.69)	(52.12)	(52.12)	(52.12)	(52.12)				
	33.00	65.00	45.00	78.00	33.00	65.00	45.00	78.00				
Composite:				63.00				63.00				
Dental Opt Out												
Employer	77.95	152.46	106.17	182.69	140.12	140.12	140.12	140.12	140.12	140.12	140.12	140.12
Employee Cash Back	(49.00)	(95.00)	(66.00)	(114.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)
FICA/PERS	(28.95)	(57.46)	(40.17)	(68.69)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)
EAP												
Employer Paid	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66
WELLNESS												
Employer Paid	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86

Exhibit: A
Page: 2

	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LIFE INSURANCE										
Face Value	$ 150,000	$ 150,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 75,000	$ 50,000	$ 50,000	$ 75,000
Employer Paid Premium	$22.20	$22.20	$6.80	$6.80	$6.80	$6.80	$10.20	$6.80	$6.80	$10.20
Face Value (Opt Down Coverage)	$ 50,000	$ 50,000								
Employer Premium	$22.88	$22.88								
Employee Cash Back	$ (11.00)	$ (11.00)								
FICA/PERS	$ (4.48)	$ (4.48)								
Premium	$ 7.40	$ 7.40								
$5000 Dependent - Employee Paid	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	
$2000 Dependent - Employer Paid										$0.38
AD&D - Employee - Employee Paid	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040
AD&D - Family - Employee Paid	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060
DISABILITY										
Short-Term Rate per $100 Salary	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24
Long-Term Rate per $100 Salary	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34
Maximum Covered Salary	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333
Employee Paid Buy-Up Max Salary	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 10,000
DEFERRED COMPENSATION										
Employer Paid	6.27%						1.00%	1-3% Match	1-3% Match	4.00%
PERS/OPSRP PENSION										
Employee Rate - County Paid	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
Employer Rate - PERS Tier 1 & 2	27.07%	25.27%	27.07%	25.27%	27.07%	27.07%	27.07%	27.07%	27.07%	27.07%
OPSRP General Service	19.22%	17.75%	19.22%	17.75%	19.22%	19.22%	19.22%	19.22%	19.22%	19.22%
OPSRP Police & Fire	23.85%						23.85%			23.85%
FICA										
Social Security	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%
Medicare	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%
RETIREE MEDICAL FUND										
Employer Paid - % of Base Salary	3.50%	(Sheriff's Office Employees Only - POA Union)								
	3.50%	(Sheriff's Office Employees Only - Command)								

Exhibit: A
Page: 3

	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LONGEVITY										
5 - 9 Years	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	$ 67.32
10-14 Years	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	$ 134.64
15-19 Years	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	$ 201.96
20-24 Years	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	$ 269.28
25-30 Years	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.0%	3.0%	3.0%	$ 336.60
30+ Years	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.5%	3.5%	3.5%	$ 403.92
VACATION ACCRUALS (MONTHLY)**										
< 5 Years	12.7	12.7	8.7	8.7	8.7	8.7	8.7	10.7	19.1	11.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
5 - 9 Years	14.0	14.0	10.7	10.7	10.7	10.7	10.7	12.7	21.1	13.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
10-14 Years	16.0	16.0	12.7	12.7	12.7	12.7	12.7	14.7	23.1	15.7
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
15-19 Years	18.0	18.0	14.7	14.7	14.7	14.7	14.7	16.0	24.4	17.0
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
20+ Years	19.3	19.3	16.7	16.7	16.7	16.7	16.7	16.7	25.1	18.3
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	360
VACATION SELLBACK ACCRUALS (MONTHLY)**										
Accrual (all years of service)	16	16	12	12	12	12	12			
Annual Maximum Carryover	280	280	250	250	250	250	250			
SICK LEAVE										
Monthly accrual	8	8	8	8	8	8	8	8	8	8
No Maximum Carryover										
HOLIDAYS										
Regular	10	10	10	10	10	10	10	10	0	10
Personal (Floating Holiday)	1	1	1	1	1	1	2	1	0	2

Note: Elected Officials do not receive longevity pay, nor do they accrue vacation, sick leave or Personal Holidays.
**Employees hired prior to 01/01/01 have a choice between the regular Vacation plan and the Vacation Sell Back plan.
Employees hired on or after 01/01/01 are enrolled in the Vacation Sell Back plan (except CCOM & POA).
Employees may sell one week of vacation each calendar year as long as they have taken at least one week of vacation during that year.
CCOM Dispatch employees earn additional vacation time in lieu of most holidays.

Exhibit: A
Page: 4

MERCER

2021 Health and Welfare Benefit Plan Preliminary Renewal Report

Clackamas County
September 2020

General County

welcome to brighter

1

Summary

The Clackamas County General County 2021 health and welfare benefit plans renewal decisions are outlined in this report.

The table on the following pages is a summary of renewal rates by plan for the General County plans.

PLAN	2020 BUDGET RATE	2021 RENEWAL	% INCREASE
Active / Retiree Medical*			
General County			
VALUE: Kaiser HMO Option 10/10/1000 $250 Deductible; Vision $250/12 months			
EE	$693.18	$675.60	-2.5%
EE, SP	1,386.38	1,351.18	-2.5%
EE, CH	1,247.74	1,216.06	-2.5%
EE, FAM	2,079.56	2,026.78	-2.5%
COMPOSITE	$1,466.68	1,435.54	-2.1%
BASE: PHP Personal Option 20/20/3000 $1000 Common Deductible (includes VSP vision)			
EE	$746.00	$777.00	4.2%
EE, SP	1,492.00	1,554.00	4.2%
EE, CH	1,345.00	1,401.00	4.2%
EE, FAM	2,241.00	2,334.00	4.1%
COMPOSITE	$1,594.00	1,651.00	3.6%
BUY-UP: PHP Open Option 20/10/30/2500 $750 Common Deductible (includes VSP vision)			
EE	$823.00	$857.00	4.1%
EE, SP	1,645.00	1,713.00	4.1%
EE, CH	1,483.00	1,545.00	4.2%
EE, FAM	2,469.00	2,571.00	4.1%
COMPOSITE	$1,933.00	2,011.00	4.0%
Retiree / Temporary Medical			
PHP $1000 Deductible			
EE	$730.63	$761.32	4.2%
EE, SP	1,461.36	$1,522.74	4.2%
EE, CH	1,315.14	$1,370.38	4.2%
EE, FAM	2,191.92	$2,283.98	4.2%
Kaiser $1000 Deductible - General County			
EE	$533.84	$520.32	-2.5%
EE, SP	1,067.68	$1,040.64	-2.5%
EE, CH	960.90	$936.58	-2.5%
EE, FAM	1,601.56	$1,561.06	-2.5%
PHP Medicare Align			
General County	$351.90	$351.90	0.0%
Kaiser Medicare			
General County	$398.54	$405.42	1.7%

Vision (VSP) – Rates and Contributions combined with Medical			
General County: VSP 12/12/12; $10/$30 copay; $130/$70 allowance			
EE	$7.00	$6.72	-4.0%
EE, SP	13.96	13.38	-4.2%
EE, CH	14.96	14.34	-4.1%
EE, FAM	23.88	22.90	-4.1%
COMPOSITE	$17.00	$16.00	-5.9%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County			
General County: Delta Dental Incentive			
EE	$91.00	$96.00	5.5%
EE, SP	183.00	194.00	6.0%
EE, CH	128.00	136.00	6.3%
EE, FAM	220.00	233.00	5.9%
COMPOSITE	$176.00	$184.00	4.5%
General County: Delta Dental Constant (50%)			
EE	$30.00	$33.00	10.0%
EE, SP	59.00	65.00	10.2%
EE, CH	41.00	45.00	9.8%
EE, FAM	70.00	78.00	11.4%
COMPOSITE	$57.00	$63.00	10.5%
General County: Delta Dental Preventive			
EE	$80.00	$84.00	5.0%
EE, SP	160.00	169.00	5.6%
EE, CH	115.00	121.00	5.2%
EE, FAM	196.00	207.00	5.6%
COMPOSITE	$158.00	$166.00	5.1%
General County/POA: Kaiser			
EE	$104.10	$104.10	0.0%
EE, SP	206.10	206.10	0.0%
EE, CH	143.66	143.66	0.0%
EE, FAM	246.68	246.68	0.0%
COMPOSITE	$190.00	$191.00	0.5%

Life and AD&D (MetLife)			
Basic Life (Rate per $1,000 benefit)			
Nonrepresented – GC	$0.148	$0.148	0.0%
Represented – GC & POA	$0.136	$0.136	0.0%
Group Universal Life			
General County and POA	Age Rated	Age Rated	0.0%
Dependent Life per Employee (Rate per Family)			
$5,000 per Dependent – GC	$2.38	$2.38	0.0%
Voluntary AD&D – General County Only (Rate per $1,000 benefit)			
Employee Only	$0.04	$0.04	0.0%
Employee and Family	$0.06	$0.06	0.0%
LTD (Standard)			
Self Insured – General County			
Funding Rate (Per $100 of Covered Salary)	$0.24	$0.24	0.0%
General Fee (PEPM)	$0.36	$0.36	0.0%
New Claim Fee (Per Claim)	$390.00	$390.00	0.0%
Open Claim Fee (Per Claim)	$19.00	$19.00	0.0%
Fully Insured – General County			
Base Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Buy-Up Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Employee Assistance Program – EAP			
Cascade (Previously with Standard)			
General Fee PEPM	$2.60	$2.66	2.3%
Flexible Spending Account			
Navia			
Monthly Fee PPPM	$5.00	$5.15	3.0%
Long Term Care – LTC			
Unum – General County			
General Fee PEPM	Age Rated	Age Rated	0.0%

**Rates include the standard 2021 contract changes.*

PEPM = Per Employee Per Month
PMPM = Per Member Per Month
PPPM = Per Participant Per Month

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2021 projection for the Open and Personal Options called for an overall 4.2% increase for the General County.

The 2021 Providence ASO fees are shown below as per employee per month (PEPM).

Providence Health Plan Administrative Fees

	2021 PEPM
Medical Administration	$32.45
Pharmacy Administration	5.41
Alternative Care Administration	2.30
Case and Disease Management	9.37
Network Access Fee	8.11
Health Coaching – 12 Sessions	2.12
	$59.76

Stop Loss Administrative Fees – Optum Health

The 2021 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is $200,000.

Mercer's underwriting projection for the 2021 renewal is included in **Exhibit A** for reference.

General County

The BRC did not elect any plan changes for the 2021 plan year:

Exhibit B contains the preliminary required 2021 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2021.

See **Exhibit C** for the Providence 2021 General County benefit summaries.

Retirees – General County

Early (pre-age 65) retirees are eligible for the Providence Personal and Open Option active employee plans.

For those early retirees who live outside of the Providence service area, the County offers the Traditional Option plan for medical coverage. These early retiree rates and prescription drug benefits are the same as the Open Option plans for active employees.

Open Option 15/30/50/2000 $1000 Common Deductible

The County elected no plan changes for the 2021 plan year. The 2021 benefit summary is included in **Exhibit C**.

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)

There is no change to the 2021 premium rate for the Providence Medicare Align plan.

Medicare Align Plan	
Medicare Align With Prescription Drug	$351.90

Exhibit B contains the standard 2021 contract changes for non-grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2021 early retiree benefit summaries.

Kaiser Permanente

General County

Kaiser proposed an overall 2.5% decrease to the 2021 premium rates.

General County

The General County did not elect to make benefit changes to this plan.

Kaiser's underwriting worksheets for their renewal calculations are included in **Exhibit D** for reference.

Exhibit E contains the 2021 contract changes provided by Kaiser. The BRC accepted the proposed 2021 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

Retirees – General County

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a $1000 deductible plan for early retirees and COBRA participants. The proposed rate decrease of 2.5% for the General County was accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. Premium rates increased by 1.7% for the General County plans.

Exhibit E contains the 2021 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The County elected to renew their vision plans with VSP. The rates for the 2021 plan year are provided in Section 1.

The VSP plan is receiving a 2-year rate guarantee. The plan will next renew January 1, 2023.

See **Exhibit G** for the 2021 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

The Incentive Plan is available to all employees. The 50 Percent Plan and Preventive Plan are only available to General County employees. All three plans are self-funded and administered by Delta Dental of Oregon (Delta).

Clackamas County is entering the second year of a three-year fee agreement with Delta. The fee for each year of the three-year agreement are as follows:

Fee per Employee per Month	2020	2021	2022
Administration fee	$6.55	$6.62	$6.69

The BRC elected the following dental plan change for the 2021 plan year:

1. A separate charge for pulp capping is not covered

Exhibit I contains the Delta administrative contract changes for 2021 for General County.

See **Exhibit J** for the 2021 Delta benefit summaries.

Underwriting

Mercer projected a 2021 combined funding increase of 5.8% for the 2021 self-insured dental plans. The County elects to apply the individual plan funding adjustments to each plan. The break out of adjustments used for the 2021 plan year is provided in the underwriting calculation in **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from April 1, 2019, through March 31, 2020. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2021 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed no increase to the 2020 premium rates.

Exhibit E contains the 2021 standard contract changes provided by Kaiser, which will be effective January 1, 2021. See **Exhibit F** for the Kaiser 2021 benefit summaries.

The 2021 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. The rates are entering the second year of a two-year year agreement.

A summary of the rates for the 2021 plan year are as follows:

General County

Basic Life	
Non-Represented Employees	$0.148/$1,000
Represented Employees	$0.136/$1,000
Dependent Life	
$5,000 per spouse/domestic partner or child	$2.38 PEPM
Voluntary Accidental Death and Dismemberment	
Employee	$0.040/$1,000
Employee and Family (spouse/domestic partner or child)	$0.060/$1,000

General County

Group Universal Life (Rates Per $1,000)		
Age	Non-Smoker Rates	Smoker Rates
< 30	$0.044	$0.066
30-34	0.048	0.074
35-39	0.062	0.102
40-44	0.096	0.150
45-49	0.164	0.224
50-54	0.270	0.330
55-59	0.424	0.518
60-64	0.640	0.798
65-69	1.186	1.270
70-74	1.986	1.986

The following levels and corresponding premium rates apply to covered dependent children:

Coverage Amount	$2,000	$4,000	$6,000	$8,000	$10,000
Monthly Rate	$0.12	$0.24	$0.36	$0.48	$0.60

Long Term Disability Insurance

The Standard

The County offers two LTD plans through The Standard as follows:

- **Base LTD Plan**
  - This coverage is provided by the County without contribution from employees. The disability benefit is 60% of the first $3,333 of monthly pre-disability income. The plan is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.

- **Buy-up LTD Plan**
  - **General County.** This plan offers General County employees the option of buying additional disability coverage, equal to 60% of the next $5,000 of monthly pre-disability earnings above $3,333 up to a maximum of $8,333.

The buy-up LTD benefit plan for the General County is 100% paid by employees on a pretax basis. The Plans have two funding components – self-funded and fully insured. Both components are administered by The Standard.

The benefits will remain unchanged for the 2021 plan year.

Fees and Premium Rates

The Standard will hold the current rates for two more years. The current rates will be in effect through December 31, 2022.

The 2021 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	$0.24 per $100 of covered payroll
Administration Fees	
General	$0.36 PEPM
New Claim	$390 per claim
Open Claim	$19 per open claim at month end
Incidental	As incurred
Insured Plan	
Base – General County	$0.34/$100
Buy-Up – General County	$0.34/$100

Employee Assistance Plan

Cascade Centers

The 2021 fee for EAP services is as follows:

Fee per Participant per Month	
Employee Assistance Program	$2.66

Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia) to provide administration for the FSA plans. The fee will increase from $5.00 per participant per month to $5.15 effective January 1, 2021. The renewal fee will be guaranteed for three years.

The 2021 fees are as follows:

Fees per Participant per Month	
Health Care FSA	$5.15
Annual Maximum	$2,500
Dependent Care FSA	$5.15
Annual Maximum	$5,000

Long Term Care Insurance

Unum

Unum insures the voluntary long term care (LTC) coverage for General County employees. There is a rate hold for the 2021 plan year.

3

Employee Contributions

General County

For FOPPO, AFSCME and Employee's Association represented employees, the County will pay 95% of the renewal composite medical/prescription/vision rate up to a collectively bargained capped composite amount.

The County will pay 95% of the tiered premium rates for nonrepresented employees.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
NONREPRESENTED				
Providence Personal Option – Base				
Employer	$738.14	$1,476.30	$1,330.94	$2,217.30
Employee	38.86	77.70	70.06	116.70
Providence Open Option – Buy-Up				
Employer	$814.14	1,627.34	1,467.74	2,442.44
Employee	42.86	85.66	77.26	128.56
Kaiser – Value				
Employer	$641.82	1,283.62	1,155.26	1,925.44
Employee	33.78	67.56	60.80	101.34
Medical Opt Out				
Cash Back	83.00	164.00	148.00	247.00
REPRESENTED				
Providence Personal Option – Base				
Employer	694.44	1,471.44	1,318.44	2,251.44
Employee	82.56	82.56	82.56	82.56
Providence Open Option – Buy-Up				
Employer	650.00	1,506.00	1,338.00	2,364.00
Employee	207.00	207.00	207.00	207.00
Kaiser – Value				
Employer	603.82	1,279.40	1,144.28	1,955.00
Employee	71.78	71.78	71.78	71.78
Medical Opt Out				
Cash Back	185.00	185.00	185.00	185.00

General County - Dental

The County pays 100% of the premium for the Delta Dental of Oregon Incentive and Preventive dental plans and the Kaiser dental plan. The Delta Dental of Oregon Constant (50%) plan and Dental Opt Out cash back for all employees are as follows:

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Delta Dental of Oregon Constant (50%)				
Nonrepresented				
Cash Back	$48.00	$94.00	$65.00	$113.00
Represented				
Cash Back	87.00	87.00	87.00	87.00
Dental Opt Out				
Nonrepresented				
Cash Back	49.00	95.00	66.00	114.00
Represented				
Cash Back	88.00	88.00	88.00	88.00

Mercer (US) Inc.
111 SW Columbia Street, Suite 500
Portland, OR 97201
www.mercer.com

MARSH & McLENNAN
COMPANIES

0120 to 0121 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice (Medical Home)

– UPDATED 09.10.2020 –

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Benefit Changes – For all plan types, except as otherwise denoted								
Section 4.7.1 language added for osteopathic manipulation	All handbooks	Adding language for osteopathic manipulation coverage to be covered under outpatient services	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Osteopathic Manipulation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, osteopathic manipulation and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	Yes	No	Currently, osteopathic office visits and **osteopathic manipulations** are both considered under the PCP office visit benefit and assessed one copay. We are changing **osteopathic manipulation** so that it is not counted as part of the PCP visit but mapped to another benefit. This means a higher cost share for the member than the current setup, where it is considered part of a PCP visit. Recommendation is to map osteopathic manipulation to the Outpatient Services benefit, subject to its own cost share, to align with PHP's intended administration of the osteopathic manipulation benefit. It is not common practice to bundle osteopathic manipulation with office visits. Note: Acceptance is *optional*.	☐ Yes ☒ No
Section 4.9.1 glucometer benefit change and additional clarifying language for limits	All handbooks	Updating language to provide greater transparency to members of how diabetes supplies/glucose monitors are covered and where they can find more information Changing benefit coverage of glucometers from Durable Medical Equipment to Diabetes Supplies	**4.9.1 Medical Supplies (including Diabetes Supplies)** ***** 2. Diabetes supplies, such as needles, syringes, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices. *****	**4.9.1 Medical Supplies (including Diabetes Supplies)** ***** 2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. ~~Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members.~~ Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as ~~glucometers and~~ insulin pump devices. *****	Yes – Glucometer changes only	No	Glucometers are currently stated as being covered under the Durable Medical Equipment Benefit. However, since they are used for testing blood levels related to Diabetes, we suggest moving glucometers to the diabetic supplies benefit so that they are covered in full. This will provide a better benefit for diabetic members. Leaving glucometers as a Durable Medical Equipment benefit applies a cost share to members. Note: Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for diabetic members. Language on test strip limits should be removed to reduce confusion, as what we actually allow is more than what is listed in the handbook. We recommend referring members to their formulary for details.	☒ Yes ☐ No

0120 to 0121 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice (Medical Home)

– UPDATED 09.10.2020 –

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administ ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4. *****	4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include ~~glucometers and~~ insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4. *****				
Section 4.10.2 removal of neurofeedback	All handbooks	Should have been removed previously to align with mental health parity	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, neurofeedback, chelation or hyperbaric chambers; *****	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy~~, neurofeedback~~, chelation or hyperbaric chambers; *****	Yes	No	The decision to remove neurofeedback as an ABA exclusion is based on PHP's interpretation of federal and state mental health parity laws. This change is also based on federal case law, which prohibits plans from including categorical exclusions for the treatment of mental health conditions (including autism). Note: Acceptance is *optional* for ASO. However, PHP recommends adoption to adhere to what we have interpreted as following mental health parity laws.	☒ Yes ☐ No
Section 4.12.17 inclusion of coverage for drug-induced Alopecia	All handbooks	Adding coverage for drug-induced Alopecia	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	Yes	Yes – OR state regulation only (OAR 836-053-0012(3)(c)(B); no federal mandate	Wigs are currently written as covered for chemotherapy, but we are suggesting to include coverage for people who have hair-loss from the same drugs as chemo, but not related to cancer. Note: Acceptance is *optional* for ASO groups that are not required to or do not electively follow state mandates. However, PHP recommends adoption to reduce barriers to health. AM Note: negligible. However Clackamas County has elected to follow all mandates. Coverage is considered accepted to comply	☒ Yes ☐ No
New section and update for biofeedback	All handbooks	New section explaining coverage for biofeedback	N/A – adding section on Biofeedback	4.12.19 Biofeedback Coverage is provided, as shown in the Benefit Summary for biofeedback to treat migraine headaches or urinary incontinence. Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	Yes	No	This is already a covered benefit for some groups. This change is to call it out for member visibility, and to align to current medical policy. Currently, it is covered by waiving the deductible and having unlimited visits.	☒ Yes ☐ No

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administ ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			5. EXCLUSIONS ***** **The Plan does not cover:** ***** • Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs; • • Thermography;	***** 5. EXCLUSIONS ***** **The Plan does not cover:** ***** • Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs; • Biofeedback, except as provided in section 4.12.19; • Thermography;			The proposal is to add biofeedback language to the handbook, and change biofeedback coverage to apply a deductible & coinsurance and have a limit of 10 visits per lifetime. Limits do not apply to Mental Health Services. Coverage would be for the following medical conditions only: migraines and urinary incontinence. Note: Acceptance is *optional*, however, PHP recommends adoption to align with medical policy. 2 questions: 1. Add to handbook per the changes noted to the left and 2. Update cost shares to apply deductible and limit to 10 visits per lifetime	
Early refill of eye drops exclusion	All handbooks	Updating language to better reflect an exclusion and when the exclusion does not apply	4.14.8 Prescription Drug Exclusions ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.	4.14.8 Prescription Drug Exclusions ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); ~~and~~ 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC~~.~~; and ~~20.~~21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. [This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.]	Yes	Yes - second sentence only applies to state abiding ASO groups (ORS 743A.065)	First sentence added to provide transparency of coverage for members that have or may require eye drops. The second bracketed sentence is required for groups that are required to or electively choose to follow state mandates. State abiding ASO groups cannot exclude early refills of eye drops for glaucoma members, per ORS 743A.065. Note: Acceptance of the second sentence is *optional* for ASO groups that are not required to or do not electively follow state mandates. However, PHP recommends adoption to provide a better benefit for members with glaucoma.	☒ Yes ☐ No
Section 5. Exclusions	All handbooks	Removing civil riot/military activities exclusion per Oregon state's direction	5. EXCLUSIONS ***** **General Exclusions:** **The Plan does not cover Services and supplies which:** ***** • Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.	5. EXCLUSIONS ***** **General Exclusions:** **The Plan does not cover Services and supplies which:** ***** • ~~Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.~~	Yes	Yes (OR state mandate only; no federal mandate)	Removing plan exclusion of coverage for any injuries or illnesses related to a member's voluntary participation in a civil riot, military services, or war-related activities. This is being done at the express direction of Oregon DFR out of their concerns of potential discrimination against: 1) military personnel who may have a pre-existing condition or may not have full access to care under their military plan, and 2) individuals who may be injured in the ongoing civil protests.	☒ Yes ☐ No

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
							Note: This change only applies to ASO groups which are required to or electively choose to follow state law. It is otherwise completely *optional* for ASO.	
Benefit Administration Changes – For all plan types, except as otherwise denoted								
Additional language added to prior authorization list	All handbooks	Adding language to callout some additional services that require prior authorization	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; *****	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; • Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	
Removal of authorizing agent language	All handbooks	Removing language around authorizing agent due to bringing services in-house	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan or their authorizing agent. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us or our authorizing agent; *****	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan ~~or our authorizing agent~~ must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan ~~or their authorizing agent~~. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us ~~or our authorizing agent~~; *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			An approved ABA treatment plan is subject to review by us or our authorizing agent, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.	An approved ABA treatment plan is subject to review by us or ~~our authorizing agent~~, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan ~~or their authorizing agent~~.				
Section 4.7.1 language added for pain management	All Handbooks	Adding language to reflect pain management benefit	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy<u>, and Multidisciplinary Pain Management Programs</u>** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, ~~and~~ therapeutic procedures<u>, and approved multidisciplinary pain management programs</u> as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	Yes	No	We need to map the Pain Management Program to the Outpatient Services benefit. Right now, the Pain Management codes are hitting the Physical Therapy benefit, but should be separated to align with the intent of the Pain Management Program. The Pain Management Program is separate from Physical Therapy. The Physical Therapy benefit has its own yearly accumulations. Changing this will be a better benefit for the member, in regards to the Pain Management Program.	
Appeals and Grievances	All Handbooks	Changing response time for non-urgent post-service claim	7.2.1 Your Grievance and Appeal Rights ***** To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. We	7.2.1 Your Grievance and Appeal Rights *****	Yes	Yes	For 2021, PHP has elected to change our ASO appeals process to follow the full 60-day notification time frame for responding to <u>non-urgent</u> <u>post-service</u> claim appeals, as expressly	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
		appeals to follow ERISA	will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines, as noted below. *****	• To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. We will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and notify you of our decision~~resolve~~ within 30 days (for non-urgent pre-service matters) or 60 days (for non-urgent post-service matters). ~~or sooner depending on the clinical urgency.~~ Urgent medical conditions and concurrent care have different resolution timelines, as noted below. *****			permitted by ERISA. [29 CFR § 2560.503-1(i)(2)(iii)(A)]. Previously, PHP followed the State standard (30-day notification time frame) for responding to this type of appeals across both fully-insured and ASO lines for simplicity and uniformity in administration. In current day, with greater resources and process flows in place, we seek to administer appeals for ASO line in accordance with the federal laws which are intended for ERISA-subject self-funded plans. Note: This change does not apply to non-ERISA ASO groups which are required to or electively choose to follow state law. State-abiding ASO groups will remain on the 30-day State standard.	
Language Changes – For all plan types, except as otherwise denoted								
Update provider directory web address	Some handbooks where existing language exists	Updating the provider directory web address to increase the ease of access	http://phppd.providence.org/	~~http://phppd.providence.org/~~ProvidenceHealthPlan.com/findaprovider	No	No	Only applies to groups that currently use the provider directory link http://phppd.providence.org/	
Updating Quick Reference Guide	All Handbooks	Updating the Customer Service Quick Reference Guide to provide correct contact information for members	Customer Service Quick Reference Guide: ***** Medical Prior Authorization Requests 800-638-0449 (toll-free) Mental Health and Chemical Dependency Prior Authorization 800-711-4577 (toll-free)	Customer Service Quick Reference Guide: ***** Medical[, Mental Health, and Chemical Dependency] Prior Authorization Requests 800-638-0449 (toll-free) 503-574-6464 (fax) ~~[Mental Health and Chemical Dependency Prior Authorization 800-711-4577 (toll-free)]~~ Provider Directory ProvidenceHealthPlan.com/findaprovider	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Adding Prior Authorization fax number and provider directory link are updates independent of brining behavioral health in-house and are effective today.	
Privacy Policy Revision	All handbooks	Removing unnecessary language	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and Your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the	No	No	Removing extraneous language. Last sentence of the paragraph under "Confidentiality and your Employer" is too detailed as the language immediately following it explains the HIPAA guidelines.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed. Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****	Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. ~~In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.~~ Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****				
Section 3.1.1 Medical Home Selection form web address	Choice (Medical Home) handbooks only	Update the link for online access to the Medical Home Selection form	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Mail your completed form to: Providence Health Plan Attn: Customer Service PO Box 3125 Portland, OR 97208 • **Email:** Download the Medical Home Selection Form from our website at	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Mail your completed form to: Providence Health Plan Attn: Customer Service PO Box ~~3125~~4327 Portland, OR 97208 • **Email:** Download the Medical Home Selection Form from our website at	No	No	Updating medical home form link.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administ ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			ProvidenceHealthPlan.com. E-mail your completed form to medicalhomeselectionforms@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Fax your completed form to 503-574-8208.	ProvidenceHealthPlan.com/medhomeform. E-mail your completed form to medicalhomeselectionforms@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Fax your completed form to 503-574-8208.				
Language update to clarify current billing process for Out-of-Network emergency services	All handbooks except Personal Option	Updating language to call out potential balance billing by Out-of-Network providers and Out-of-Network Hospitals	**4.5.1 Emergency Care** ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. *****	**4.5.1 Emergency Care** ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 4.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR. *****	No	No	Language update necessary to advise members of potential balance billing by Out-Of-Network providers and Out-Of-Network hospitals (unless otherwise prohibited by state or federal law), even when emergency services are covered at an In-Network benefit until the member is stable and able to be transferred to an In-Network facility.	
Section 4.12.14 additional clarifying language	All handbooks	Providing clarifying language about the type of treatment of Gender Dysphoria that is subject to Medical Necessity	**4.12.14 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see	**4.12.14 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. ~~Treatment~~ Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may	No	No	Language update necessary to accurately reflect that *surgical* treatment of gender dysphoria is subject to medical necessity review.	

Exhibit: C
Page: 8

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			section 3.5 for a list of services requiring Prior Authorization. *****	apply. Please see section 4.4 for a list of services requiring Prior Authorization. *****				
Language update to reflect override allowances	All handbooks	Updating language to better reflect available benefits	4.14.7 Prescription Drug Limitations ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.	4.14.7 Prescription Drug Limitations ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan. ~~7.~~8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis. ~~8.~~9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.	No	No	Language update necessary to provide greater transparency of medication override benefits for members and limits to the coverage.	
Prescription combination drugs exclusion	All handbooks	Updating language to better reflect scope of existing exclusion	4.14.8 Prescription Drug Exclusions ***** 11. Drugs placed on a prescription-only status as required by state or local law;	4.14.8 Prescription Drug Exclusions ***** 11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;	No	No	This language change clarifies the scope of the existing prescription drug exclusion.	
Removing address due to in-house services	All handbooks	Removing the address due to bringing services in-house Correcting P.O. Box number	6.1.1 Timely Submission of Claims ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box 4327 Portland, OR 97208-4327 Mental Health and Chemical Dependency claims should be submitted to:	6.1.1 Timely Submission of Claims ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box 3125 ~~4327~~ Portland, OR 97208-3125~~4327~~ ~~Mental Health and Chemical Dependency claims should be submitted to:~~	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Reverting claims PO Box number back to 3125 as it was changed in error.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			PBH PO Box 30602 Salt Lake City, UT 84130 *****	~~PBH~~ ~~PO Box 30602~~ ~~Salt Lake City, UT 84130~~ *****				
Section 8 language modification	All handbooks	Modified language to improve readability	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide us with evidence of eligibility as requested. *****	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide ~~us~~ Providence Health Plan with evidence of eligibility as requested. *****	No	No	Updating reference to Providence Health Plan to avoid confusion	

KAISER PERMANENTE®

2021 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups (General County Plans)

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2021. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus® medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- For Deductible and High Deductible Health Plans, we have added selected preventive care services to be covered without a deductible for individuals diagnosed with specific chronic conditions, as allowed under the IRS and US Treasury Department Notice 2019-45.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified to indicate that the cost share for insulin is not subject to Deductible and will not exceed $100 per 30-day supply.
- The "Maternity and Newborn Care" section of the *EOC* and Benefit Summary has been modified to indicate that newborn nurse home visiting Services are covered as required per Oregon Senate Bill 526.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions has been added to the list of covered DME under the "Outpatient Durable Medical Equipment (DME)" section of the *EOC*.

Benefit clarifications

- The "Post-Stabilization Care" section of *EOC* has been modified to clarify that these benefit provisions apply to covered Services from vendors, such as providers of Durable Medical Equipment (DME).
- The "Preventive Care Services" section of the *EOC* has been modified. A bullet has been added to the confirm coverage for any state-required reproductive health preventive Services for all Members.
- The "Chemical Dependency Services" section of the *EOC* has been modified. A statement has been added to confirm that the benefits in this section comply with the federal Mental Health Parity and Addiction Equity Act.

- The term "DME formulary" is being removed from the "Outpatient Durable Medical Equipment (DME)" and "External Prosthetic Devices and Orthotic Devices" sections for clarity and to reduce confusion with "formulary" in reference to prescription drug benefits.
- The "External Prosthetic Devices and Orthotic Devices" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy and consistency within the contract. Language has been added to specify that Services are covered subject to Utilization Review.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been revised for better alignment with the requirements of ORS 743A.141.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified for alignment across products. A parenthetical was added, excepting insulin from the "Injectable drugs that are self-administered" exclusion.
- The "Mental Health Services" section of the *EOC* and the Benefit Summary have been modified to clarify that partial hospitalization is a covered Service.
- The "Outpatient Durable Medical Equipment" section of the *EOC* has been modified to clarify that both blood glucose monitors and continuous glucose monitors are covered.
- The Low-Vision Aids and Vision Hardware and Optical Services exclusions in the Exclusions and Limitations section of the *EOC* have been modified for clarity to include a cross reference to the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."
- The "Exclusions and Limitations" section of the *EOC* has been modified. The surrogacy limitation clarifies that it applies to both traditional and gestational surrogacy arrangements.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The term Cost Share has been defined and added to the "Definitions" section of the *EOC*. Throughout all documents, the defined term Cost Share replaces some, but not all, instances of Deductible, Copayments, or Coinsurance used for improved readability, accuracy, and administrative purposes.
- The terms Non-Participating Vendor and Participating Vendor have been added to the "Definitions" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* for alignment across products.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services" section of the *EOC*, has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.
- The definition of Spouse has been modified to clarify that the term includes a person who is validly registered as a domestic partner under the laws of another state.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- The "Prior and Concurrent Authorization and Utilization Review" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is

required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, and Appeals" section.

- The "Out-of-Pocket Maximum" section of the *EOC* has been modified to remove an incorrect reference to payments for Services under the "Alternative Care Services" section of the *EOC* as the *EOC* does not contain this section.
- The "Out-of-Pocket Maximum" section of the *EOC* has been modified for accuracy. The bullets indicating that payments for Services under the "Infertility Services" section and the "Infertility Treatment Services Rider" have been removed. Payments for these Services do apply to the "Out-of-Pocket Maximum."
- Throughout the *EOC*, references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Surrogacy Arrangements" section of the *EOC* has been modified to clarify that the section applies to both traditional and gestational surrogacy arrangements.
- The "Grievances, Claims, Appeals, and External Review" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.
- The "Moving to Another Kaiser Foundation Health Plan Service Area" section of the *EOC* has been modified to clarify that a Member may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan Service Area, rather than transferring to another plan, as they would still need to meet the eligibility requirements of the new plan.
- The "Unusual Circumstances" section of the *EOC* has been modified to clarify that, in the event of unusual circumstances that could result in delay or inability to provide covered Services, Kaiser Permanente will make a good faith effort to provide or arrange for Services within the limitations of available personnel and facilities.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in all tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements," "Tier 3 Out-of-Pocket Maximum," and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a

Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor, or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "How to Obtain Services - General Information" section of the *EOC* has been modified for accuracy. The language noting Urgent Care as an exception to the Tier 1 requirements has been removed. Only Emergency Services received at a PPO Facility or Non-Participating Facility are covered under Tier 1. Urgent Care Services received at a PPO Facility or Non-Participating Facility are covered under Tier 2 or Tier 3, whichever applies.
- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3" section of the *EOC* has been modified. The list of Services that do not require prior authorization in Tier 2 and Tier 3 has been revised for clarity and accuracy.
- The "Tier 2 and Tier 3 Urgent Care" section of the *EOC* has been modified to clarify that we cover Urgent Care under Tier 2 or Tier 3. The language indicating that if a Member receives Urgent Care that is not covered under Tier 1 has been removed as Urgent Care is covered under Tier 1. We do not cover Services in Tier 2 or Tier 3 that are not covered under Tier 1.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Tier 1 Prior Authorization Review Requirements" and the "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections of the *EOC* have been updated to The "Prior and Concurrent Authorization and Utilization Review" section of the *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Additional changes and clarifications that apply to PPO Plus® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in both tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements" and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor,

or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "General Information" subsection under "How to Obtain Services" has been modified for accuracy. The language regarding an exception to the Tier 1 requirements has been revised to clarify that Emergency Services received at a Non-Participating Facility are not subject to these requirements.
- The "Services Subject to Prior Authorization Review" section of the *EOC* has been modified. The list of Services that do not require prior authorization has been revised for clarity and accuracy.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Prior Authorization Review Requirements" section of the *EOC* has been modified to reflect that prior authorization determinations will be provided within two business days per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Changes and clarifications that apply to medical benefit riders

Benefit changes

- The "Cost Share for Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" used for Added Choice and PPO Plus plans has been modified to reflect a change in how the Member cost share is applied for drugs obtained from MedImpact Pharmacies when a generic equivalent is available, but the Member chooses a brand-name drug. Language stating that the Member would pay the difference between the pharmacy's retail price for the brand-name drug and the generic drug, in addition to the applicable drug tier cost share, has been removed. Members will now only pay the Copayment or Coinsurance for the brand-name drug.

Benefit clarifications

- The "Medication Management Program" section of the "Outpatient Prescription Drug Rider" has been modified for clarity.

Administrative changes or clarifications

- Throughout the riders, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services Rider," has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.

- Language has been added to the "Hearing Aid Rider" to clarify that the hearing aid allowance is combined across all tiers under which hearing aids are covered.
- The first paragraph of the "Infertility Treatment Services" section in the "Infertility Treatment Services Rider" has been modified for alignment with other products. Language indicating that Services are covered "only under Tier 1" has been removed as this concept is discussed later in the rider.
- The "Infertility Treatment Services Rider" has been modified. The language indicating that the Lifetime Benefit Maximum is combined across all tiers has been moved from the rider benefit summary table to the text of the rider.
- The Member Services phone number has been removed throughout the "Outpatient Prescription Drug Rider" templates to align with the *EOC*.
- Throughout the "Outpatient Prescription Drug Rider," references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Outpatient Prescription Drug Rider" for plans that cover sexual dysfunction drugs has been modified. The bullet limiting sexual dysfunction drugs to eight pills per a 30-day supply has been removed as this limit is captured in the "You Pay" cell of the Sexual Dysfunction drugs row on the Rider Benefit Summary Table for plans that have the limit.

Changes and clarifications that apply to dental plans

Benefit clarifications

- Minor edits were made for clarity to the exclusion for government agency responsibility in the "Exclusions" section of the *EOC*.
- The exclusion for use of alternative materials in the "Exclusions" section of the *EOC* was modified to improve readability and understanding.
- A new limitation has been added to clarify that routine fillings are limited to amalgam or glass ionomer fillings on posterior teeth and composite fillings on anterior teeth. This limitation does not change how fillings are currently restored.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The column for In and Out-of-Network Benefit Maximum in the PPO *EOCs* was split from one to two columns for administrative ease and clarity.
- Language in various sections throughout the *EOC* has been modified to align with similar sections across products and lines of business. This synchronization did not result in any benefit or administrative changes.
- References to online directories have been updated where applicable to ensure accuracy.
- The definitions of Dentally Necessary and Medically Necessary have been revised to eliminate redundancy when defining Services.
- The definition of Spouse has been modified to clarify that a person who is validly registered as your domestic partner under the laws of another state is defined as a Spouse.

- The reference to "effective date" in the "When Coverage Begins" section has been updated to "membership effective date" and other references throughout the *EOC* to "effective date of coverage" for clarity.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- References to dental claim forms in the "Post-Service Claims - Services Already Received" section have been updated for accuracy.
- The PPO *EOCs* have been revised to clarify that all care and Service must be directed by a Participating or Non-Participating Provider within the United States.
- United States Food and Drug Administration was updated to U.S. Food and Drug Administration (FDA) for consistency and accuracy.
- The term "Calendar" was removed from all limitations referring to "Calendar Year." The defined term is Year.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Grievances, Claims, and Appeals" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- A note has been added to the "Dental Implant Benefit" section clarifying that pontics are not covered under the Dental Implant Services Rider but under the "Major Restorative Services" section of the *EOC*.
- The first bullet under the "Exclusions" section of the Dental Implant Services Rider has been modified for clarity. An implant or any part of an implant surgically placed prior to a Member's effective date of Company coverage is not covered. This clarification supports current administration.
- A new limitation has been added to the Implant rider to clarify that removing and reinserting a prosthesis and abutments for cleaning is limited to implants placed by a Permanente Dental Associates Participating Dentist. This will enable Participating Dentists to maintain consistent and high quality of care. This clarification supports current administration.

KAISER PERMANENTE®

Administrative changes or clarifications

- The first bullet under the "General Benefit Requirements" section of the Dental Implant Services Rider has been modified to clarify that all care and Service must be directed by a Participating or Non-Participating Provider.
- References to "effective date" have been updated to "effective date of coverage" for clarity.
- References to "charges" in the Dental Implant Services Rider and Orthodontic Services Rider have been removed to accurately reflect the Member's cost share as "coinsurance."

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart located at the front of the *EOC*:
  - Acupuncture for chronic low back pain has been added. This is a CMS benefit change effective January 21, 2020 and was not previously included in the Chart.
  - More detail about covered services has been added to the "Colorectal cancer screening" section of the Chart to describe cost-sharing for colonoscopies.
  - The "Durable medical equipment (DME) and related supplies" section has been revised to add phototherapy equipment for home use to treat psoriasis to the items covered at $0 cost sharing, and also to list DME items not covered by Medicare but covered by us when medically necessary.
  - The Silver&Fit® Healthy Aging and Exercise Program benefit description has been revised. Members who enroll in Silver&Fit may choose all or some of the available options: basic gym membership, two "Home Fitness" kits, and one "Stay Fit" kit.
  - More detail has been added to the "Home infusion therapy" section to describe covered services necessary to perform home infusion, including drugs, equipment, supplies, professional services, patient training and education, and monitoring.
  - Three specific lab tests for persons with certain chronic conditions have been added to the "Outpatient diagnostic tests and therapeutic services and supplies" section and are covered at $0 cost-sharing (not subject to deductible, if applicable), for all members.
  - Sleep studies have been added as a covered item in the "Outpatient diagnostic tests and therapeutic services and supplies" section.
  - The "Physician/practitioner services, including doctor's office visits" section has been revised. We have added information to explain when the outpatient surgery cost-sharing is applied. The description of covered telehealth services has also been modified for clarity.
- A new Section 8 has been added to Chapter 3 of the *EOC* to describe what oxygen benefits (equipment, supplies and maintenance) a Senior Advantage member is entitled to; what is the cost-sharing; and how coverage is affected if a member leaves our plan and returns to Original Medicare.
- A paragraph has been added to Chapter 4, Section 1 of the *EOC* – "Understanding your out-of-pocket costs for covered services" – to inform members there is no cost-sharing related to COVID-19 testing or treatment for the duration of the public health emergency.
- We have removed genetic testing from the exclusions or limitations chart in Chapter 4 of the *EOC* because genetic testing is covered by Medicare in certain situations.

- Several *EOC* definitions have been revised for clarity and accuracy, including the terms Emergency Medical Condition, Exception, Network Physician, and Plan.

Administrative changes and clarifications

- The Senior Advantage eligibility requirements in Chapter 1, Section 2.1 of the *EOC* have changed to remove enrollment restrictions on beneficiaries with ESRD, in accordance with the 21st Century Cares Act.
- In Chapter 1, Section 2.3 of the *EOC*, we have added Lane County in Oregon to our plan service area for Senior Advantage.
- For Medicare Part D plans, Chapter 1, Section 3.5 of the *EOC* has been revised to explain the additional information provided on the Part D Explanation of Benefits (EOB).
- For Medicare Part D plans, Chapter 2, Section 1 of the *EOC* has been revised to provide new contact information for Part D prescription drugs coverage decisions.
- For Medicare plans that do not include Part D prescription drug coverage, Chapter 2, Section 7 of the *EOC* – "Programs that help pay for prescription drugs" – has been modified to provide additional information about prescription cost-sharing assistance programs for persons with HIV/AIDS.
- For Medicare Part D plans, Chapter 5, Section 10.2 of the *EOC* has been revised to provide additional information about the Drug Management Program and member appeals related to limits or restrictions on opioid medications.
- A new Section 18, "Surrogacy," has been added to the "Legal Notices" chapter of the *EOC* to explain our right to seek reimbursement of plan charges for covered services that a member receives associated with a surrogacy arrangement.

Clackamas County
Oregon ASO Dental Plan Changes
Renewing January 1, 2021
(Preliminary draft as of 8/20/2020)

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2021. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
	Additional changes may be required as a result of new federal rules or regulations.	Delta Dental will provide written notice of any additional changes.	TBD

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☒	☐	**Benefits and Limitations** Pulp Capping	Pulp capping was covered only when there was exposure of the pulp.	A separate charge for pulp capping is not covered.	Pulp capping is performed at the same time as a restorative service and should be included in the charge of the restoration.	-0.02%
☐	☒	**Benefits and Limitations** Re-cement and Re-bond	Re-cement or re-bond of a crown, inlay, onlay or veneer are covered.	Re-cement or re-bond of a crown, inlay, onlay or veneer, by the same dentist, is limited to once per lifetime.	In an otherwise healthy tooth, a properly placed restoration should not need continuous efforts to maintain its attachment.	Negligible

ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Minor wording changes for readability.	This includes separating 1 sentence into 2, and replacing some words with simpler synonyms (e.g., consult changed to talk with)
General Exclusions Illegal Acts, Riot, Rebellion	Narrow the exclusion to require member be convicted of a crime for the exclusion to be applied.	Oregon Department of Consumer and Business Services request. Will ensure that protesters who have not committed a crime will have coverage if injured.
Claims Administration & Payment Order of Benefit Determination	The plan will now coordinate benefits with Medicare.	The new Medicare COB process will comply with the Oregon and Federal rules.

ASO AGREEMENT CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
None		

*Based on Delta Dental book of business.

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations or State law. Delta Dental will provide written notice of any additional changes including any modification to administrative fees, and will administer such changes accordingly.

Services are provided by Oregon Dental Service doing business as Delta Dental Plan of Oregon (Delta Dental). Delta Dental is part of the Moda organization.

Signature Evelyn Minor-Lawrence, IPMA-CP Digitally signed by Evelyn Minor-Lawrence, IPMA-CP Date: 2020.09.17 17:20:33 -07'00' **Date** 09/17/2020

2021 Health and Welfare Benefit Plan Preliminary Renewal Report

Clackamas County
September 2020

Peace Officers Association

1

Summary

The Clackamas County Peace Officers Association (POA) 2021 health and welfare benefit plans renewal decisions are outlined in this report.

The table on the following pages is a summary of renewal rates by plan for the POA plans.

PLAN	2020 BUDGET RATE	STATUS QUO 2021 RENEWAL	% INCREASE
Active / Retiree Medical*			
POA			
Kaiser HMO Option			
EE	$707.84	$689.88	-2.5%
EE, SP	1,415.70	1,379.76	-2.5%
EE, CH	1,274.12	1,241.78	-2.5%
EE, FAM	2,123.54	2,069.64	-2.5%
COMPOSITE	$1,553.58	$1,571.44	1.1%
PHP Personal Option 15/0/1000 (Includes VSP Vision)			
EE	$771.00	$805.00	4.4%
EE, SP	1,542.00	1,609.00	4.3%
EE, CH	1,390.00	1,450.00	4.3%
EE, FAM	2,316.00	2,417.00	4.4%
COMPOSITE	$1,870.00	$1,960.00	4.8%
PHP Open Option 10/0/20/2000 $50 Common Deductible (Includes VSP Vision)			
EE	$825.00	$861.00	4.4%
EE, SP	1,648.00	1,720.00	4.4%
EE, CH	1,486.00	1,551.00	4.4%
EE, FAM	2,474.00	2,582.00	4.4%
COMPOSITE	$1,998.00	$2,086.00	4.4%
Retiree / Temporary Medical			
PHP $1000 Deductible			
EE	$730.63	$761.32	4.2%
EE, SP	1,461.36	1,522.74	4.2%
EE, CH	1,315.14	1,370.38	4.2%
EE, FAM	2,191.92	2,283.98	4.2%
Kaiser $1000 Deductible - POA			
EE	$533.90	$520.32	-2.5%
EE, SP	1,067.80	1,040.64	-2.5%
EE, CH	961.02	936.58	-2.5%
EE, FAM	1,601.82	1,561.06	-2.5%
PHP Medicare Align			
POA	$351.90	$351.90	0.0%
Kaiser Medicare			
POA	$391.10	$396.44	1.4%

Vision (VSP) – Rates and Contributions combined with Medical			
POA: VSP 12/24/24; $10 copay; $130 allowance			
EE	$3.90	$3.74	-4.1%
EE, SP	7.82	7.50	-4.1%
EE, CH	8.36	8.02	-4.1%
EE, FAM	13.38	12.84	-4.0%
COMPOSITE	$10.54	$10.10	-4.2%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County			
POA: Delta Dental Incentive			
EE	$73.00	$74.00	1.4%
EE, SP	143.00	146.00	2.1%
EE, CH	103.00	105.00	1.9%
EE, FAM	174.00	177.00	1.7%
COMPOSITE	$147.00	$150.00	2.0%
General County/POA: Kaiser			
EE	$104.10	$104.10	0.0%
EE, SP	206.10	206.10	0.0%
EE, CH	143.66	143.66	0.0%
EE, FAM	246.68	246.68	0.0%
COMPOSITE	$190.00	$191.00	0.5%

Life and AD&D (MetLife)			
Basic Life (Rate per $1,000 benefit)			
Represented – GC & POA	$0.136	$0.136	0.0%
Group Universal Life			
General County and POA	Age Rated	Age Rated	0.0%
Dependent Life per Employee (Rate per Family)			
$2,000 per Dependent – POA	$0.38	$0.38	0.0%
LTD (Standard)			
Fully Insured – Peace Officers			
Base Plan (Per $100 of Covered Salary)	$0.30	$0.30	0.0%
Buy-Up Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Employee Assistance Program – EAP			
Cascade (Previously with Standard)			
General Fee PEPM	$2.60	$2.66	2.3%
Flexible Spending Account			
Navia			
Monthly Fee PPPM	$5.00	$5.15	3.0%

**Rates include the standard 2021 contract changes.*

PEPM = Per Employee Per Month
PMPM = Per Member Per Month
PPPM = Per Participant Per Month

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2021 projection for the Open and Personal Options called for an overall 4.4% increase for the POA.

The 2021 Providence ASO fees are shown below as per employee per month (PEPM).

Providence Health Plan Administrative Fees

	2021 PEPM
Medical Administration	$32.45
Pharmacy Administration	5.41
Alternative Care Administration	2.30
Case and Disease Management	9.37
Network Access Fee	8.11
Health Coaching – 12 Sessions	2.12
	$59.76

Stop Loss Administrative Fees – Optum Health

The 2021 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is $200,000.

Mercer's underwriting projection for the 2021 renewal is included in **Exhibit A** for reference.

Peace Officers

There were no plan changes for the 2021 plan year for the POA plans.

The standard 2021 contract changes summary for grandfathered plans in **Exhibit B** apply to the POA plans.

See **Exhibit C** for the Providence 2021 POA benefit summaries.

Retirees – Peace Officers

Early (pre-age 65) retirees are eligible for the Providence Personal and Open Option active employee plans.

For those early retirees who live outside of the Providence service area, the County offers the Traditional Option plan for medical coverage. These early retiree rates and prescription drug benefits are the same as the Open Option plans for active employees.

Open Option 15/30/50/2000 $1000 Common Deductible
The County elected no plan changes for the 2021 plan year. The 2021 benefit summary is included in **Exhibit C**.

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)
There is no change to the premium rate for the Providence Medicare Align plan.

Medicare Align Plan

Medicare Align With Prescription Drug	$351.90

Exhibit B contains the standard 2021 contract changes for grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2021 early retiree benefit summaries.

Kaiser Permanente

Peace Officers

Kaiser proposed an overall 2.5% decrease to the 2020 premium rates.

POA

The POA did not elect to make benefit changes to this plan.

Kaiser's underwriting worksheets for their renewal calculations are included in **Exhibit D** for reference.

Exhibit E contains the 2021 contract changes provided by Kaiser. The POA accepted the proposed 2021 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

Retirees – Peace Officers

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a $1,000 deductible plan for early retirees and COBRA participants. The proposed rate decrease of 2.5% for the POA plan was accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. Premium rates increased by 1.4%.

Exhibit E contains the 2021 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The County elected to renew their vision plans with VSP for POA. The rates for the 2020 plan year are provided in Section 1.

The VSP plan is receiving a 2-year rate guarantee. The plan will next renew January 1, 2023.

See **Exhibit G** for the 2021 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

The Incentive Plan is available to all employees.

Clackamas County is entering the second year of a three-year fee agreement with Delta. The fee for each year of the three-year agreement are as follows:

Rates per Employee per Month	2020	2021	2022
Administration fee	$6.55	$6.62	$6.69

The POA elected the following dental plan change for the 2021 plan year:

1. A separate charge for pulp capping is not covered
2. Re-cement or re-bond of a crown, inlay, onlay or veneer by the same dentist is limited to once per lifetime

Exhibit I contains the Delta administrative contract changes for 2021 for POA.

See **Exhibit J** for the 2021 Delta benefit summaries.

Underwriting

Mercer projected a 2021 funding increase of 1.9% for the 2021 self-insured dental plan. See **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from April 1, 2019, through March 31, 2020. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2021 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed no increase to the 2020 premium rates.

Exhibit E contains the 2021 standard contract changes provided by Kaiser, which will be effective January 1, 2021. See **Exhibit F** for the Kaiser 2021 benefit summaries.

The 2021 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. The rates are entering the second year of a two-year year agreement.

A summary of the rates for the 2021 plan year are as follows:

Peace Officer Association

Basic Life	
Represented Employees	$0.136/$1,000
Dependent Life	
$2,000 per spouse/domestic partner or child	$0.38 PEPM

Long Term Disability Insurance

The Standard

The County offers two LTD plans through The Standard as follows:

- **Base LTD Plans**
  - **POA.** This coverage is provided by the County without contributions from employees. The disability benefit is 60% of the first $3,333 of monthly pre-disability income. The plan

is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.

- **Buy-up LTD Plans**
  - **Peace Officers.** This plan offers POA employees the option of buying additional disability coverage, equal to 60% of the next $6,667 of monthly pre-disability earnings above $3,333 up to a maximum of $10,000.

The buy-up LTD benefit plans for Peace Officers are 100% paid by employees on a pretax basis. The Plans have two funding components – self-funded and fully insured. Both components are administered by Standard.

The benefits will remain unchanged for the 2021 plan year.

Fees and Premium Rates

The Standard will hold the current rates for two more years. The current rates will be in effect through December 31, 2022.

The 2021 funding, premium, and fees are as follows:

Self-Insured Plan	
Administration Fees	
General	$0.36 PEPM
New Claim	$390 per claim
Open Claim	$19 per open claim at month end
Incidental	As incurred
Insured Plan	
Base – Peace Officers	$0.30/$100
Buy-Up – Peace Officers	$0.34/$100

Employee Assistance Plan

Cascade Centers

The 2021 fee for EAP services is as follows:

Fee per Participant per Month	
Employee Assistance Program	$2.66

Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia) to provide administration for the FSA plans. The fee will increase from $5.00 per participant per month to $5.15 effective January 1, 2021. The renewal fee will be guaranteed for three years.

The 2021 fees are as follows:

Fees per Participant per Month	
Health Care FSA	$5.15
Annual Maximum	$2,500
Dependent Care FSA	$5.15
Annual Maximum	$5,000

3

Employee Contributions

Peace Officers

The County pays 95% of the premium for the Providence medical plans. However, if the premium increases more than 10% in any one year, the County and the employees shall evenly split the increased costs above 10%. The County pays 100% of the premium for employees enrolled in the Kaiser medical plan.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Providence Personal Option				
Employer	$707.00	$1,511.00	$1,352.00	$2,319.00
Employee	$98.00	$98.00	$98.00	$98.00
Providence Open Option				
Employer	$756.70	$1,615.70	$1,446.70	$2,477.70
Employee	$104.30	$104.30	$104.30	$104.30
Kaiser				
Employer	$689.88	$1,379.76	$1,241.78	$2,069.64
Employee	$0.00	$0.00	$0.00	$0.00
HRA VEBA				
Cash Back	$176.00	$176.00	$176.00	$176.00

The County pays 100% of the premium for the Delta Dental of Oregon and Kaiser dental plans. The County removed the dental contribution for all employees. The Dental Opt Out cash back for all employees is as follows.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Dental Opt Out				
Cash Back	$88.00	$88.00	$88.00	$88.00

Mercer (US) Inc.
111 SW Columbia Street, Suite 500
Portland, OR 97201
www.mercer.com

MARSH & McLENNAN
COMPANIES

0120 to 0121 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

- UPDATED 09.10.2020 -

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Benefit Changes – For all plan types, except as otherwise denoted								
Section 4.9.1 glucometer benefit change and additional clarifying language for limits	All handbooks	Updating language to provide greater transparency to members of how diabetes supplies/glucose monitors are covered and where they can find more information Changing benefit coverage of glucometers from Durable Medical Equipment to Diabetes Supplies	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 2. Diabetes supplies, such as needles, syringes, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices. ***** 4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. ~~Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members.~~ Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as ~~glucometers and~~ insulin pump devices. ***** 4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include ~~glucometers and~~ insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.	Yes – Glucometer changes only	No	Glucometers are currently stated as being covered under the Durable Medical Equipment Benefit. However, since they are used for testing blood levels related to Diabetes, it makes sense to move glucometers to the diabetic supplies benefit so that they are covered in full. This will provide a better benefit for diabetic members. Leaving glucometers as a Durable Medical Equipment benefit applies a cost share to members. Note: Acceptance is *optional*. This change is made to provide a better benefit for diabetic members. Language on test strip limits should be removed to reduce confusion, as what we actually allow is more than what is listed in the handbook. Members are referred to their formulary for details. **IMPORTANT NOTE:** For grandfathered plans, once a new or richer benefit is added to the plan, the ASO employer **cannot** thereafter eliminate or significantly reduce that benefit, unless permitted by subsequent new law.	☒ Yes ☐ No
Section 4.10.2 removal of neurofeedback	All handbooks	Should have been removed previously to align with mental health parity	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, neurofeedback, chelation or hyperbaric chambers; *****	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy~~, neurofeedback~~, chelation or hyperbaric chambers; *****	Yes	No	The decision to remove neurofeedback as an ABA exclusion is based on PHP's interpretation of federal and state mental health parity laws. Ths change is also based on federal case law, which prohibits plans from including categorical exclusions for the treatment of mental health conditions (including autism). Note: Acceptance is *optional* for ASO. PHP is making this change to adhere to what we have interpreted as following mental health parity laws.	☒ Yes ☐ No

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
							IMPORTANT NOTE: For grandfathered plans, once a new or richer benefit is added to the plan, the ASO employer **cannot** thereafter eliminate or significantly reduce that benefit, unless permitted by subsequent new law.	
Section 4.12.17 inclusion of coverage for drug-induced Alopecia	All handbooks	Adding coverage for drug-induced Alopecia	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	Yes	Yes – OR state regulation only (OAR 836-053-0012(3)(c)(B); no federal mandate	Wigs are currently written as covered for chemotherapy, but we are adding coverage for people who have hair-loss from the same drugs as chemo, but not related to cancer. Note: Acceptance is *required* for ASO groups that electively follow state mandates.	
Early refill of eye drops exclusion	All handbooks	Updating language to better reflect an exclusion and when the exclusion does not apply	4.14.8 Prescription Drug Exclusions ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.	4.14.8 Prescription Drug Exclusions ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); ~~and~~ 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC~~.~~; and ~~20.~~21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. [This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.]	Yes	Yes - second sentence only applies to state abiding ASO groups (ORS 743A.065)	First sentence added to provide transparency of coverage for members that have or may require eye drops. The second bracketed sentence is required for groups that are required to or electively choose to follow state mandates. State abiding ASO groups cannot exclude early refills of eye drops for glaucoma members, per ORS 743A.065. Note: Acceptance of the second sentence is *required* for ASO groups that electively follow state mandates.	
Section 5. Exclusions	All handbooks	Removing civil riot/military activities exclusion per Oregon state's direction	5. EXCLUSIONS ***** General Exclusions: The Plan does not cover Services and supplies which: ***** Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.	5. EXCLUSIONS ***** General Exclusions: The Plan does not cover Services and supplies which: ***** ~~Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.~~	Yes	Yes (OR state mandate only; no federal mandate)	Removing plan exclusion of coverage for any injuries or illnesses related to a member's voluntary participation in a civil riot, military services, or war-related activities. This is being done at the express direction of Oregon DFR out of their concerns of potential discrimination against: 1) military personnel who may have a pre-existing condition or may not have full access to care under their military plan, and 2) individuals who may be injured in the ongoing civil protests. Note: Acceptance is *required* for ASO groups that electively follow state mandates.	

0120 to 0121 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

- UPDATED 09.10.2020 -

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Benefit Administration Changes – For all plan types, except as otherwise denoted								
Additional language added to prior authorization list	All handbooks	Adding language to callout some additional services that require prior authorization	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; *****	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; • Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	
Removal of authorizing agent language	All handbooks	Removing language around authorizing agent due to bringing services in-house	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan or their authorizing agent. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us or our authorizing agent; ***** An approved ABA treatment plan is subject to review by us or our authorizing agent, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services *****	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan ~~or our authorizing agent~~ must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan ~~or their authorizing agent~~. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us ~~or our authorizing agent~~; ***** An approved ABA treatment plan is subject to review by us or ~~our authorizing agent~~, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.	Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan ~~or their authorizing agent~~.				
Section 4.7.1 language added for pain management	All Handbooks	Adding language to reflect pain management benefit	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy**, and Multidisciplinary Pain Management Programs Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, ~~and~~ therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	Yes	No	We need to map the Pain Management Program to the Outpatient Services benefit. Right now, the Pain Management codes are hitting the Physical Therapy benefit, but should be separated to align with the intent of the Pain Management Program. The Pain Management Program is separate from Physical Therapy. The Physical Therapy benefit has its own yearly accumulations. Changing this will be a better benefit for the member, in regards to the Pain Management Program.	
Language Changes – For all plan types, except as otherwise denoted								
Update provider directory web address	Some handbooks where existing language exists	Updating the provider directory web address to increase the ease of access	http://phppd.providence.org/	~~http://phppd.providence.org/~~ProvidenceHealthPlan.com/findaprovider	No	No	Only applies to groups that **currently** use the provider directory link http://phppd.providence.org/	
Updating Quick Reference Guide	All Handbooks	Updating the Customer Service Quick Reference Guide to provide correct contact information for members	**Customer Service Quick Reference Guide:** ***** Medical Prior Authorization Requests 800-638-0449 (toll-free) Mental Health and Chemical Dependency Prior Authorization 800-711-4577 (toll-free)	**Customer Service Quick Reference Guide:** ***** Medical[, Mental Health, and Chemical Dependency] Prior Authorization Requests 800-638-0449 (toll-free) 503-574-6464 (fax) [~~Mental Health and Chemical Dependency Prior Authorization~~	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Adding Prior Authorization fax number and provider directory link are updates independent of brining behavioral health in-house and are effective today.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
				~~800-711-4577 (toll-free)~~] Provider Directory ProvidenceHealthPlan.com/findaprovider				
Privacy Policy Revision	All handbooks	Removing unnecessary language	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and Your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed. Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. ~~In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.~~ Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****	No	No	Removing extraneous language. Last sentence of the paragraph under "Confidentiality and your Employer" is too detailed as the language immediately following it explains the HIPAA guidelines.	
Language update to clarify current billing process for Out-of-Network emergency services	All handbooks except Personal Option	Updating language to call out potential balance billing by Out-of-Network providers and Out-of-Network Hospitals	4.5.1 Emergency Care ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. *****	4.5.1 Emergency Care ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are	No	No	Language update necessary to advise members of potential balance billing by Out-Of-Network providers and Out-Of-Network hospitals (unless otherwise prohibited by state or federal law), even when emergency services are covered at an In-Network benefit until the member is stable and able to be transferred to an In-Network facility.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
				covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 4.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR. *****				
Section 4.12.14 additional clarifying language	All handbooks	Providing clarifying language about the type of treatment of Gender Dysphoria that is subject to Medical Necessity	4.12.14 Gender Dysphoria Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization. *****	4.12.14 Gender Dysphoria Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. ~~Treatment~~ Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 4.4 for a list of services requiring Prior Authorization. *****	No	No	Language update necessary to accurately reflect that *surgical* treatment of gender dysphoria is subject to medical necessity review.	
Language update to reflect override allowances	All handbooks	Updating language to better reflect available benefits	4.14.7 Prescription Drug Limitations ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.	4.14.7 Prescription Drug Limitations ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan. ~~7.~~8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis. ~~8.~~9. A 30 day supply medication refill override will be granted if you are out of medication and	No	No	Language update necessary to provide greater transparency of medication override benefits for members and limits to the coverage.	

0120 to 0121 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

- UPDATED 09.10.2020 -

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
				have not yet received your drugs from a participating mail order pharmacy.				
Prescription combination drugs exclusion	All handbooks	Updating language to better reflect scope of existing exclusion	4.14.8 Prescription Drug Exclusions ***** 11. Drugs placed on a prescription-only status as required by state or local law;	4.14.8 Prescription Drug Exclusions ***** 11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;	No	No	This language change clarifies the scope of the existing prescription drug exclusion.	
Removing address due to in-house services	All handbooks	Removing the address due to bringing services in-house Correcting P.O. Box number	6.1.1 Timely Submission of Claims ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box 4327 Portland, OR 97208-4327 Mental Health and Chemical Dependency claims should be submitted to: PBH PO Box 30602 Salt Lake City, UT 84130 *****	6.1.1 Timely Submission of Claims ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box ~~4327~~3125 Portland, OR 97208-~~4327~~3125 ~~Mental Health and Chemical Dependency claims should be submitted to:~~ ~~PBH~~ ~~PO Box 30602~~ ~~Salt Lake City, UT 84130~~ *****	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Reverting claims PO Box number back to 3125 as it was changed in error.	
Section 8 language modification	All handbooks	Modified language to improve readability	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide us with evidence of eligibility as requested. *****	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide ~~us~~ Providence Health Plan with evidence of eligibility as requested. *****	No	No	Updating reference to Providence Health Plan to avoid confusion	

Exhibit: G
Page: 7

KAISER PERMANENTE®

2021 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups (POA Plans)

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2021. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus® medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- For Deductible and High Deductible Health Plans, we have added selected preventive care services to be covered without a deductible for individuals diagnosed with specific chronic conditions, as allowed under the IRS and US Treasury Department Notice 2019-45.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified to indicate that the cost share for insulin is not subject to Deductible and will not exceed $100 per 30-day supply.
- The "Maternity and Newborn Care" section of the *EOC* and Benefit Summary has been modified to indicate that newborn nurse home visiting Services are covered as required per Oregon Senate Bill 526.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions has been added to the list of covered DME under the "Outpatient Durable Medical Equipment (DME)" section of the *EOC*.

Benefit clarifications

- The "Post-Stabilization Care" section of *EOC* has been modified to clarify that these benefit provisions apply to covered Services from vendors, such as providers of Durable Medical Equipment (DME).
- The "Preventive Care Services" section of the *EOC* has been modified. A bullet has been added to the confirm coverage for any state-required reproductive health preventive Services for all Members.
- The "Chemical Dependency Services" section of the *EOC* has been modified. A statement has been added to confirm that the benefits in this section comply with the federal Mental Health Parity and Addiction Equity Act.

- The term "DME formulary" is being removed from the "Outpatient Durable Medical Equipment (DME)" and "External Prosthetic Devices and Orthotic Devices" sections for clarity and to reduce confusion with "formulary" in reference to prescription drug benefits.
- The "External Prosthetic Devices and Orthotic Devices" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy and consistency within the contract. Language has been added to specify that Services are covered subject to Utilization Review.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been revised for better alignment with the requirements of ORS 743A.141.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified for alignment across products. A parenthetical was added, excepting insulin from the "Injectable drugs that are self-administered" exclusion.
- The "Mental Health Services" section of the *EOC* and the Benefit Summary have been modified to clarify that partial hospitalization is a covered Service.
- The "Outpatient Durable Medical Equipment" section of the *EOC* has been modified to clarify that both blood glucose monitors and continuous glucose monitors are covered.
- The Low-Vision Aids and Vision Hardware and Optical Services exclusions in the Exclusions and Limitations section of the *EOC* have been modified for clarity to include a cross reference to the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."
- The "Exclusions and Limitations" section of the *EOC* has been modified. The surrogacy limitation clarifies that it applies to both traditional and gestational surrogacy arrangements.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The term Cost Share has been defined and added to the "Definitions" section of the *EOC*. Throughout all documents, the defined term Cost Share replaces some, but not all, instances of Deductible, Copayments, or Coinsurance used for improved readability, accuracy, and administrative purposes.
- The terms Non-Participating Vendor and Participating Vendor have been added to the "Definitions" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* for alignment across products.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services" section of the *EOC*, has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.
- The definition of Spouse has been modified to clarify that the term includes a person who is validly registered as a domestic partner under the laws of another state.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- The "Prior and Concurrent Authorization and Utilization Review" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is

required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, and Appeals" section.

- The "Out-of-Pocket Maximum" section of the *EOC* has been modified to remove an incorrect reference to payments for Services under the "Alternative Care Services" section of the *EOC* as the *EOC* does not contain this section.
- The "Out-of-Pocket Maximum" section of the *EOC* has been modified for accuracy. The bullets indicating that payments for Services under the "Infertility Services" section and the "Infertility Treatment Services Rider" have been removed. Payments for these Services do apply to the "Out-of-Pocket Maximum."
- Throughout the *EOC*, references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Surrogacy Arrangements" section of the *EOC* has been modified to clarify that the section applies to both traditional and gestational surrogacy arrangements.
- The "Grievances, Claims, Appeals, and External Review" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.
- The "Moving to Another Kaiser Foundation Health Plan Service Area" section of the *EOC* has been modified to clarify that a Member may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan Service Area, rather than transferring to another plan, as they would still need to meet the eligibility requirements of the new plan.
- The "Unusual Circumstances" section of the *EOC* has been modified to clarify that, in the event of unusual circumstances that could result in delay or inability to provide covered Services, Kaiser Permanente will make a good faith effort to provide or arrange for Services within the limitations of available personnel and facilities.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in all tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements," "Tier 3 Out-of-Pocket Maximum," and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a

Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor, or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "How to Obtain Services - General Information" section of the *EOC* has been modified for accuracy. The language noting Urgent Care as an exception to the Tier 1 requirements has been removed. Only Emergency Services received at a PPO Facility or Non-Participating Facility are covered under Tier 1. Urgent Care Services received at a PPO Facility or Non-Participating Facility are covered under Tier 2 or Tier 3, whichever applies.
- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3" section of the *EOC* has been modified. The list of Services that do not require prior authorization in Tier 2 and Tier 3 has been revised for clarity and accuracy.
- The "Tier 2 and Tier 3 Urgent Care" section of the *EOC* has been modified to clarify that we cover Urgent Care under Tier 2 or Tier 3. The language indicating that if a Member receives Urgent Care that is not covered under Tier 1 has been removed as Urgent Care is covered under Tier 1. We do not cover Services in Tier 2 or Tier 3 that are not covered under Tier 1.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Tier 1 Prior Authorization Review Requirements" and the "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections of the *EOC* have been updated to The "Prior and Concurrent Authorization and Utilization Review" section of the *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Additional changes and clarifications that apply to PPO Plus® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in both tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements" and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor,

or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "General Information" subsection under "How to Obtain Services" has been modified for accuracy. The language regarding an exception to the Tier 1 requirements has been revised to clarify that Emergency Services received at a Non-Participating Facility are not subject to these requirements.
- The "Services Subject to Prior Authorization Review" section of the *EOC* has been modified. The list of Services that do not require prior authorization has been revised for clarity and accuracy.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Prior Authorization Review Requirements" section of the *EOC* has been modified to reflect that prior authorization determinations will be provided within two business days per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Changes and clarifications that apply to medical benefit riders

Benefit changes

- The "Cost Share for Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" used for Added Choice and PPO Plus plans has been modified to reflect a change in how the Member cost share is applied for drugs obtained from MedImpact Pharmacies when a generic equivalent is available, but the Member chooses a brand-name drug. Language stating that the Member would pay the difference between the pharmacy's retail price for the brand-name drug and the generic drug, in addition to the applicable drug tier cost share, has been removed. Members will now only pay the Copayment or Coinsurance for the brand-name drug.

Benefit clarifications

- The "Medication Management Program" section of the "Outpatient Prescription Drug Rider" has been modified for clarity.

Administrative changes or clarifications

- Throughout the riders, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services Rider," has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.

- Language has been added to the "Hearing Aid Rider" to clarify that the hearing aid allowance is combined across all tiers under which hearing aids are covered.
- The first paragraph of the "Infertility Treatment Services" section in the "Infertility Treatment Services Rider" has been modified for alignment with other products. Language indicating that Services are covered "only under Tier 1" has been removed as this concept is discussed later in the rider.
- The "Infertility Treatment Services Rider" has been modified. The language indicating that the Lifetime Benefit Maximum is combined across all tiers has been moved from the rider benefit summary table to the text of the rider.
- The Member Services phone number has been removed throughout the "Outpatient Prescription Drug Rider" templates to align with the *EOC*.
- Throughout the "Outpatient Prescription Drug Rider," references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Outpatient Prescription Drug Rider" for plans that cover sexual dysfunction drugs has been modified. The bullet limiting sexual dysfunction drugs to eight pills per a 30-day supply has been removed as this limit is captured in the "You Pay" cell of the Sexual Dysfunction drugs row on the Rider Benefit Summary Table for plans that have the limit.

Changes and clarifications that apply to dental plans

Benefit clarifications

- Minor edits were made for clarity to the exclusion for government agency responsibility in the "Exclusions" section of the *EOC*.
- The exclusion for use of alternative materials in the "Exclusions" section of the *EOC* was modified to improve readability and understanding.
- A new limitation has been added to clarify that routine fillings are limited to amalgam or glass ionomer fillings on posterior teeth and composite fillings on anterior teeth. This limitation does not change how fillings are currently restored.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The column for In and Out-of-Network Benefit Maximum in the PPO *EOCs* was split from one to two columns for administrative ease and clarity.
- Language in various sections throughout the *EOC* has been modified to align with similar sections across products and lines of business. This synchronization did not result in any benefit or administrative changes.
- References to online directories have been updated where applicable to ensure accuracy.
- The definitions of Dentally Necessary and Medically Necessary have been revised to eliminate redundancy when defining Services.
- The definition of Spouse has been modified to clarify that a person who is validly registered as your domestic partner under the laws of another state is defined as a Spouse.

- The reference to "effective date" in the "When Coverage Begins" section has been updated to "membership effective date" and other references throughout the *EOC* to "effective date of coverage" for clarity.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- References to dental claim forms in the "Post-Service Claims - Services Already Received" section have been updated for accuracy.
- The PPO *EOCs* have been revised to clarify that all care and Service must be directed by a Participating or Non-Participating Provider within the United States.
- United States Food and Drug Administration was updated to U.S. Food and Drug Administration (FDA) for consistency and accuracy.
- The term "Calendar" was removed from all limitations referring to "Calendar Year." The defined term is Year.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Grievances, Claims, and Appeals" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- A note has been added to the "Dental Implant Benefit" section clarifying that pontics are not covered under the Dental Implant Services Rider but under the "Major Restorative Services" section of the *EOC*.
- The first bullet under the "Exclusions" section of the Dental Implant Services Rider has been modified for clarity. An implant or any part of an implant surgically placed prior to a Member's effective date of Company coverage is not covered. This clarification supports current administration.
- A new limitation has been added to the Implant rider to clarify that removing and reinserting a prosthesis and abutments for cleaning is limited to implants placed by a Permanente Dental Associates Participating Dentist. This will enable Participating Dentists to maintain consistent and high quality of care. This clarification supports current administration.

KAISER PERMANENTE®

Administrative changes or clarifications

- The first bullet under the "General Benefit Requirements" section of the Dental Implant Services Rider has been modified to clarify that all care and Service must be directed by a Participating or Non-Participating Provider.
- References to "effective date" have been updated to "effective date of coverage" for clarity.
- References to "charges" in the Dental Implant Services Rider and Orthodontic Services Rider have been removed to accurately reflect the Member's cost share as "coinsurance."

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart located at the front of the *EOC*:
  - Acupuncture for chronic low back pain has been added. This is a CMS benefit change effective January 21, 2020 and was not previously included in the Chart.
  - More detail about covered services has been added to the "Colorectal cancer screening" section of the Chart to describe cost-sharing for colonoscopies.
  - The "Durable medical equipment (DME) and related supplies" section has been revised to add phototherapy equipment for home use to treat psoriasis to the items covered at $0 cost sharing, and also to list DME items not covered by Medicare but covered by us when medically necessary.
  - The Silver&Fit® Healthy Aging and Exercise Program benefit description has been revised. Members who enroll in Silver&Fit may choose all or some of the available options: basic gym membership, two "Home Fitness" kits, and one "Stay Fit" kit.
  - More detail has been added to the "Home infusion therapy" section to describe covered services necessary to perform home infusion, including drugs, equipment, supplies, professional services, patient training and education, and monitoring.
  - Three specific lab tests for persons with certain chronic conditions have been added to the "Outpatient diagnostic tests and therapeutic services and supplies" section and are covered at $0 cost-sharing (not subject to deductible, if applicable), for all members.
  - Sleep studies have been added as a covered item in the "Outpatient diagnostic tests and therapeutic services and supplies" section.
  - The "Physician/practitioner services, including doctor's office visits" section has been revised. We have added information to explain when the outpatient surgery cost-sharing is applied. The description of covered telehealth services has also been modified for clarity.
- A new Section 8 has been added to Chapter 3 of the *EOC* to describe what oxygen benefits (equipment, supplies and maintenance) a Senior Advantage member is entitled to; what is the cost-sharing; and how coverage is affected if a member leaves our plan and returns to Original Medicare.
- A paragraph has been added to Chapter 4, Section 1 of the *EOC* – "Understanding your out-of-pocket costs for covered services" – to inform members there is no cost-sharing related to COVID-19 testing or treatment for the duration of the public health emergency.
- We have removed genetic testing from the exclusions or limitations chart in Chapter 4 of the *EOC* because genetic testing is covered by Medicare in certain situations.

- Several *EOC* definitions have been revised for clarity and accuracy, including the terms Emergency Medical Condition, Exception, Network Physician, and Plan.

Administrative changes and clarifications

- The Senior Advantage eligibility requirements in Chapter 1, Section 2.1 of the *EOC* have changed to remove enrollment restrictions on beneficiaries with ESRD, in accordance with the 21st Century Cares Act.
- In Chapter 1, Section 2.3 of the *EOC*, we have added Lane County in Oregon to our plan service area for Senior Advantage.
- For Medicare Part D plans, Chapter 1, Section 3.5 of the *EOC* has been revised to explain the additional information provided on the Part D Explanation of Benefits (EOB).
- For Medicare Part D plans, Chapter 2, Section 1 of the *EOC* has been revised to provide new contact information for Part D prescription drugs coverage decisions.
- For Medicare plans that do not include Part D prescription drug coverage, Chapter 2, Section 7 of the *EOC* – "Programs that help pay for prescription drugs" – has been modified to provide additional information about prescription cost-sharing assistance programs for persons with HIV/AIDS.
- For Medicare Part D plans, Chapter 5, Section 10.2 of the *EOC* has been revised to provide additional information about the Drug Management Program and member appeals related to limits or restrictions on opioid medications.
- A new Section 18, "Surrogacy," has been added to the "Legal Notices" chapter of the *EOC* to explain our right to seek reimbursement of plan charges for covered services that a member receives associated with a surrogacy arrangement.

Clackamas County (POA)
Oregon ASO Dental Plan Changes
Renewing January 1, 2021
(Preliminary draft as of 8/20/2020)

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2021. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
	Additional changes may be required as a result of new federal rules or regulations.	Delta Dental will provide written notice of any additional changes.	TBD

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☑	☐	**Benefits and Limitations** Pulp Capping	Pulp capping was covered only when there was exposure of the pulp.	A separate charge for pulp capping is not covered.	Pulp capping is performed at the same time as a restorative service and should be included in the charge of the restoration.	-0.02%
☑	☐	**Benefits and Limitations** Re-cement and Re-bond	Re-cement or re-bond of a crown, inlay, onlay or veneer are covered.	Re-cement or re-bond of a crown, inlay, onlay or veneer, by the same dentist, is limited to once per lifetime.	In an otherwise healthy tooth, a properly placed restoration should not need continuous efforts to maintain its attachment.	Negligible

ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Minor wording changes for readability.	This includes separating 1 sentence into 2, and replacing some words with simpler synonyms (e.g., consult changed to talk with)
General Exclusions Illegal Acts, Riot, Rebellion	Narrow the exclusion to require member be convicted of a crime for the exclusion to be applied.	Oregon Department of Consumer and Business Services request. Will ensure that protesters who have not committed a crime will have coverage if injured.
Claims Administration & Payment Order of Benefit Determination	The plan will now coordinate benefits with Medicare.	The new Medicare COB process will comply with the Oregon and Federal rules.

ASO AGREEMENT CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
None		

*Based on Delta Dental book of business.

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations or State law. Delta Dental will provide written notice of any additional changes including any modification to administrative fees, and will administer such changes accordingly.

Services are provided by Oregon Dental Service doing business as Delta Dental Plan of Oregon (Delta Dental). Delta Dental is part of the Moda organization.

Signature **Date**

Retiree, COBRA and Temporary Employee Low Cost Medical Plan Options

Executive Summary

Problem Statement:
The Clackamas County benefits division created the Providence and Kaiser $1000 deductible plans to provide more affordable medical plan options for retired employees and COBRA participants. The plan design for the Providence and Kaiser $1000 deductible plans, which are now also available to full-time temporary employees, have not been changed since the inception of these plans in 2005 and 2006. Consequently, the premiums associated with these plans are less affordable resulting in increasing costs to county departments, retired employees and COBRA participants.

Project Coordinator: Jason Morrill, HR Analyst

Review Team: Tamra Dickinson, Benefits and Wellness Coordinator; Billie Hurley, HR Analyst; Christi Hardy, HR Assistant

Internal Stakeholders: Benefits and Wellness Division, County Departments, Temporary Employees, County Unions, Employee & Labor Relations, Independent Retiree Medical Trust (IRMT), Workforce Data Management Division, Technical Services.

External Stakeholders: Retirees, COBRA Participants, William C Earhart Company, Mercer, Providence Health Plan, Kaiser Permanente.

Recommendation: Since the Kaiser $1000 deductible plan is the basis for determining the value of minimum essential coverage, and consequently the employer contribution amount, we recommend retaining this plan as the lowest cost option for temporary employees, retirees and COBRA participants. Since the Kaiser plan only provides coverage within the Oregon and Washington Kaiser service district, we also recommend retaining the Providence $1000 deductible plan as a lower cost option for retiree and COBRA participants living both inside and outside of the Kaiser service district.

We recommend combining rates for the two Kaiser $1000 deductible plans (general county and POA), since these plans are nearly identical and are already in the same rate pool. This consolidation will not have a meaningful impact on the plan rates, but will reduce administrative complexity and retiree/COBRA participant confusion.

Finally, we recommend making plan design changes to both the Kaiser and Providence $1000 deductible plans to reduce costs and maintain choice. This will involve renaming the plans as “high deductible” plans instead of $1000 deductible plans. These changes will reduce the cost to departments associated with maintaining temporary employees. It will also provide employees seeking to retire with lower cost options for medical insurance in retirement, thereby making it more practical for employees to afford retiring from Clackamas County.

We are proposing the following changes for the 2021 plan year:

<u>Kaiser plans (GC & POA):</u>
Increase deductible to $1400/$2800
Increase pharmacy benefit to $20/$40

<u>Providence Plan:</u>
Increase deductible to $1400/$2800
Increase out of pocket maximum to $3000/$6000
Increase office visit copay to $25

- See $1000 deductible plan options (Attachment A) for the premium impact associated with the changes.
- See $1000 deductible plan comparison (Attachment B) for current 2020 plan coverage options.

Going forward, we recommend increasing the deductible as needed to comply with the definition of a high deductible health plan (https://www.healthcare.gov/glossary/high-deductible-health-plan/). Other changes may also be necessary in the future to retain variation among the plan options and continue to meet the affordability guidelines of the Affordable Care Act (ACA) (https://acatimes.com/irs-safe-harbors-for-affordability-help-avoid-aca-penalties/) for active employees while continuing to comply with ACA minimum essential coverage requirements.

Background: In 2005, Clackamas County implemented the $1000 deductible Providence Open Option medical plan for general county (GC) retiree and COBRA participants. In 2006, Clackamas County added two Kaiser $1000 deductible plans (GC and POA) and extended the $1000 deductible Providence Open Option medical plan to the POA retiree and COBRA population. Clackamas County has not made any plan changes to the $1000 deductible plans since their inception.

In response to the Affordable Care Act's (ACA) employer mandate, Clackamas County began offering the $1000 deductible plans to temporary employees meeting certain eligibility criteria to satisfy Clackamas County's requirement to provide minimum essential coverage as of January 1, 2016.

Through post-educational class employee surveys, the benefits and wellness team has learned that one barrier employees experience for retirement is the cost associated with medical insurance.

Other Organizations: Our analysis shows that other similar organizations in our region also provide low cost plans as an option for retired employees. Multnomah County has two "major medical" plans, Washington County offers two "high deductible" medical plans, and Lane County has one "high deductible" medical plan available for their retiree populations. These plans are lower in cost and coverage than their other employee and retiree plans.

Current State: Clackamas County has three $1000 deductible medical plan options that are available to retirees, COBRA participants and temporary employees meeting certain eligibility criteria. These plans include:

Coverage Tier:	**Kaiser General County (GC) $1000 deductible**	**Kaiser POA $1000 deductible**	**Providence GC & POA $1000 deductible**
Individual	$533.84 / Month	$533.90 / Month	$730.63 / Month
Individual & Spouse	$1,067.68 / Month	$1,067.80 / Month	$1,461.36 / Month
Individual & Child(ren)	$960.90 / Month	$961.02 / Month	$1,315.14 / Month
Family	$1,601.56 / Month	$1,601.82 / Month	$2,191.92 / Month

*Rates are for the 2020 calendar year.

Retirees and COBRA participants pay 100% of the premiums associated with the $1000 deductible plans. The employing department pays $533.84 per employee per month (PEPM) for temporary employees enrolled in a $1000 deductible plan, and the temporary employee pays the remaining premiums. The employer premium for qualifying temporary employees is based on the least expensive $1000 deductible plan, which is currently the general county Kaiser $1000 deductible plan.

As of September 2020, here is the distribution of use:

	Kaiser General County (GC) $1000 deductible	**Kaiser POA $1000 deductible**	**Providence GC & POA $1000 deductible**	**Eligible, not enrolled**
Retiree /COBRA	8	7	14	N/A
Temporary	9	0	2	28

Estimated financial impact: If all plan changes are implemented, the combined departmental savings for 2021 based on current enrollment levels will be $2,349.60. If additional eligible temporary employees elect medical benefits for 2021, the potential savings would be up to $8,330.40.

Premium reductions associated with these changes will be passed on to retiree and COBRA participants in full. The 2021 annual premium savings for each retiree are:

Coverage Tier:	**Kaiser (GC & POA) $1000 deductible**	**Providence (GC & POA) $1000 deductible**
Individual	$213.60	$347.28
Individual & Spouse	$427.20	$694.32
Individual & Child(ren)	$384.48	$624.96
Family	$640.80	$1,041.60

Review Begin Date: 6/29/2020

Review End Date: 9/3/2020

Clackamas County January 2021 Renewal
Temps/Retirees/COBRA - $1,000 Deductible Plan Options
General County & POA

August 24, 2020

PLAN	GC & POA Blended Renewal No Plan Changes	$1,400/$2,800 Deductible	$20/$40 Rx Copays	Both Plan Options
Kaiser $1,000 Deductible				
EE	$520.32	$506.14	$516.58	$502.52
EE, SP	1,040.64	1,012.28	1,033.18	1,005.04
EE, CH	936.58	911.04	929.86	904.54
EE, FAM	1,561.06	1,518.50	1,549.86	1,507.66

PLAN	GC & POA Blended Renewal No Plan Changes	$1,400/$2,800 Deductible	$3,000/$6,000 OOP Maximum	$25 Office Visit Copay	All Plan Options
Providence $1,000 Deductible					
EE	$761.32	$759.80	$738.48	$758.28	$732.38
EE, SP	1,522.74	1,519.70	1,477.06	1,516.64	1,464.88
EE, CH	1,370.38	1,367.64	1,329.26	1,364.90	1,318.30
EE, FAM	2,283.98	2,279.42	2,215.46	2,274.84	2,197.18

Attachment B:

Clackamas County - 2020 $1000 Deductible Plan Comparison (Temporary Employees, Non-Medicare Retirees and COBRA)	GC Kaiser High Deductible Plan	POA Kaiser High Deductible Plan	Providence High Deductible Open Option	
	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY	IN-PLAN	OUT-OF-PLAN
Annual Deductible: Individual/Family	$1000/$3000	$1000/$3000	$1000/$2000 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$3000/$9000	$3000/$9000	$2000/$4000 Common Maximum	
PREVENTIVE SERVICES				
Periodic health exams	Covered in full	Covered in full	Covered in full	50%*
Well baby care, routine immunizations	Covered in full	Covered in full	Covered in full	50%*
Gynecology exams & tests	Covered in full	Covered in full	Covered in full	50%*
Mammograms	Covered in full	Covered in full	Covered in full	50%
Colonscopy & sigmoidoscopy	Covered in full	Covered in full	Covered in full	50%
PHYSICIAN/PROVIDER SERVICES				
Office visits	$25* primary care; 20% specialty care	$25* primary care; 20% specialty care	$15*	50%*
Allergy shots	Covered in full	Covered in full	30%	50%
Pre-natal & post-natal visits; delivery	Covered in full	Covered in full	$100*/pregnancy	50%
HOSPITAL SERVICES				
Inpatient care & provider visits	20%	20%	30%	50%
Maternity services	20%	20%	30%	50%
Routine newborn nursery care	20%	20%	30%*	50%
Surgery & anesthesia	20%	20%	30%	50%
Rehabilitative care (subject to limitations)	20%	20%	30%	50%
Skilled nursing facility (subject to limitations)	20%	20%	30%	50%
DURABLE MEDICAL EQUIPMENT				
Medical supplies, appliances and prosthetics	20%	20%	30%	50%
Diabetic equipment (glucose monitors, insulin pumps, etc)	20%	20%	30%	50%
EMERGENCY/URGENT & AMBULANCE SERVICES				
Emergency services	20%	20%	$100*	$100*
Urgent care services	$25*	$25*	$15*	50%*
Emergency medical transportation	20%	20%	30%	30%
OTHER COVERED SERVICES				
X-ray & lab services	20%	20%	30%*	50%
Outpatient rehabilitative services	20%* (limited to 20 visits per therapy per year)	20%* (limited to 20 visits per therapy per year)	30%	50%
Outpatient surgery	20%	20%	30%	50%
Chemotherapy & radiation	20%	20%	30%	50%
Home health care (subject to limitations)	20%	20%	30%	50%
Hospice	Covered in full	Covered in full	Covered in full	Covered in full
HEARING AID ALLOWANCE				
Children	20% - One hearing aid per ear every 4 years	20% - One hearing aid per ear every 4 years	30% (One per ear every 4 years)	50% (One per ear every 4 years)
Adults	$1500 allowance every 3 years for each ear	$1500 allowance every 3 years for each ear	30% (One per ear every 4 years)	50% (One per ear every 4 years)
VISION				
Children Vision - every year	Exam and standard lenses/frames or 12 months supply of contact lenses: Covered in full	Exam and standard lenses/frames or 12 months supply of contact lenses: Covered in full	Discount available	Discount available
Vision Examinations - every 12 months	$25 co pay*	$25 co pay*	Discount available	
Benefit every 12/24 months	$200 for lenses and frames or contact lenses every 2 years	$200 for lenses and frames or contact lenses every 2 years	Discount available	
ALTERNATIVE CARE				
Office visits	$10 for chiropractic, acupuncture, naturopath², $25 massage, $1500 combined annual max	$10 for chiropractic, acupuncture, naturopath², $25 massage, $1500 combined annual max	$25 co pay* for chiropractic and acupuncture***	N/A
PRESCRIPTION DRUGS				
Generic/Brand at pharmacy	$15/$30	$15/$30	$10*/50%*	N/A
Generic/Brand for 90-day mail (maint. drugs)	$30/$60	$30/$60	$30*/50%*	N/A

***Deductible does not apply**

****Physician-referred acupuncture visits is limited to 12 visits per calendar year**

*****Participants may be responsible for more than 1 co-pay depending on how their provider bills Providence for their services. Eligible naturopathic services are billed as physician/provider services.**

²Physician-referred acupuncture visits is limited to 12 visits per calendar year

Effective January 1, 2020 to December 31, 2020