CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS

Study Session Worksheet

Presentation Date: 10/21/14 **Approximate Start Time:** 2:00 pm **Approximate Length:** 1 hour

Presentation Title: Benefits Renewals for 2015; Medical Self Insurance

Department: Employee Services

Presenters: Nancy Drury, Director of Employee Services
Carolyn Williams, Benefits Manager
Jan Long, Mercer
Joe Bober, Mercer

Other Invitees: N/A

WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?
DES is seeking formal approval to renew contracts with benefit providers for the 2015 plan year. Contracts 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 final approval.

We are also seeking approval to:
- Contract directly with VSP for vision benefits
- Update the Health Care Flexible Spending Account program plan document to replace the current grace period with a $500 rollover provision
- Change the funding method for Providence medical plans from fully insured to self insured with stop loss insurance

EXECUTIVE SUMMARY:
The Department of Employee Services and its employee benefits consultant, Mercer, have completed negotiations with the County's insurance carriers and third party administrators for the 2015 employee benefit plan renewals. The County must confirm the renewals prior to November 1, 2014 to ensure coverage for the 2015 plan year. See attached Renewal Report for detailed information on the 2015 renewals.

Medical
All of the County's medical plans are renewing with rate decreases. The Benefits Review Committee voted to make some plan changes that consumed part of the cost savings. Final renewals for the General County Providence plans were -3.0% for the Personal Option and -1.9% for the Open Option. For the Peace Officers' Providence plans, the decreases were -4.3% for the Personal Option and -5.2% for the Open Option. The Kaiser Medical plans for both General County and Peace Officers had a decrease -0.4%. The national trend for medical plan increases is 6.8%.

Vision
Vision benefits for Providence members are provided by VSP through a contract with Providence. Because the vision plan is wrapped within a medical plan, some of the provisions of the Affordable Care Act apply, including the requirement that pediatric vision (age 0-18) is provided with no out-of-pocket costs. In order to keep the plan affordable, this means there is a very limited choice in lenses and frames, most of which are not appropriate for teenagers.

By contracting directly with VSP, we have more flexibility in designing coverage for adults and children, including a greater selection of pediatric frames, more coverage for progressive lenses,

and a wider variety of providers at a significant costs savings from keeping the plan with Providence.

Dental
The self-insured dental plans administered by Moda rates changes ranged from a decrease of -17.4% to an increase of 9.6%. The fully-insured Kaiser dental plan will increase by 5.9%. It is not unusual for dental plan rate to be volatile. The Benefits Self Insurance Fund can easily cover the increases. In comparison, the current dental market trend is 5-7%.

Other Benefits
There will be no rate changes to the group term life, dependent life or group universal life insurance provided through Met Life.

The fully-insured long-term disability coverage provided though Standard Insurance will have a 0% increase. For the self-insured short-term disability program, there will be a 13.3% increase in the funding rate, from $0.15 to $0.17 per $100 covered salary.

The employee-paid long term care coverage rates will increase by 15%. This is the first rate increase since the program was implemented in 2000.

There were no premium changes for accidental death and dismemberment, wellness and employee assistance program, or flexible spending account administration.

Nonrepresented Employee Cost Sharing
The current practice for nonrepresented employees is to provide benefit cost sharing in a similar manner as represented employees so that there is no disincentive to promote into a management or supervisory position and for the County to remain competitive in attracting and retaining employees. Under the current cost sharing method, the County pays 95% and the employee pays 5% of the tiered medical premium and the County pays 100% of the dental, life and disability premiums and the administrative costs for the flexible spending accounts.

Health Care Flexible Spending Account (FSA) Program Plan Documents
One of the provisions of the Health Care FSA is a "use it or lose it" rule. Employees were required to use all of the funds in their account by the end of the plan year (December 31). In the past, the IRS allowed plans to allow a 2½ month "grace period" where employees had until March 15th following the end of the plan year to spend the prior year funds. In 2014, the IRS created another option that allows employees to "carryover" up to $500 into the following plan year.

The Benefits Review Committee reviewed both options and voted unanimously to recommend that the County adopt the $500 carryover feature instead of the grace period feature for the 2015 plan year. In 2013, there were 182 employees with forfeitures under $500 and only 22 who used the grace period.

Self Insured Medical
Most employers the size of Clackamas County self-insure the medical coverage provided to their employees. Occasionally over the past several years, DES has evaluated the market and the County's financial relationship with Providence and had determined that the current refunding arrangement was in the County's best interest.

Recently, the health insurance landscape has changed significantly, primarily due to the Affordable Care Act (ACA). By self insuring the Providence plans, the County could reduce its costs by not having to pay certain taxes that Providence pays and then passes through to the County's premiums (2% state premium tax, 1% Healthy Oregon premium tax, new ACA insurer tax).

In addition, by being self insured, the County would have the ability to have in depth claims analysis where we could provide our employees and families with data on which providers follow best practices and have better outcomes at the most reasonable prices.

We recommend that the County move to the self-insured model for the 2015 plan year. However, POA has made a demand to bargain the impact of self insurance which may delay implementation to a later year.

Kaiser does not administer self insured plans so this recommendation applies only to the Providence plans. Kaiser would remain fully insured.

FINANCIAL IMPLICATIONS (current year and ongoing):
If the Providence medical plans remain fully insured, the estimated fiscal impact for the 2015 plan year will be:

Medical:	$(538,700)
Dental:	54,200
STD	17,600
Total:	$(466,900)

We estimate an additional $400,000 in savings by self insuring the Providence plans.

LEGAL/POLICY REQUIREMENTS:
Employee benefits must be provided as required under the collective bargaining agreements and County policy.

PUBLIC/GOVERNMENTAL PARTICIPATION:
N/A

OPTIONS:
It is highly unlikely that the County would be able to negotiate lower increases or find any other carrier willing to offer lower rates over a sustained period of time. In addition, we have developed strong business partner relationships with our carriers.

RECOMMENDATION:
1. Approve renewal contracts with Kaiser, MODA, Metropolitan Life, Standard Insurance and Flex-Plan.
2. Approve a new contract with VSP for vision coverage.
3. Approve paying 95% of the premiums for the medical coverage, and 100% of the premiums for dental, life, and disability plans for nonrepresented employees.
4. Approve the revisions to the Health Care Flexible Spending Account plan document.
5. Approve self funding the medical plans administered by Providence Health Plans.

ATTACHMENTS:
Mercer's 2014 Health and Welfare Benefit Plan Renewal Report
Health Care Flexible Spending Account plan document
Mercer Health Plan Funding Options

SUBMITTED BY:
Division Director/Head Approval C Williams
Department Director/Head Approval
County Administrator Approval

For information on this issue or copies of attachments,
please contact Carolyn Williams @ 503-742-5470.

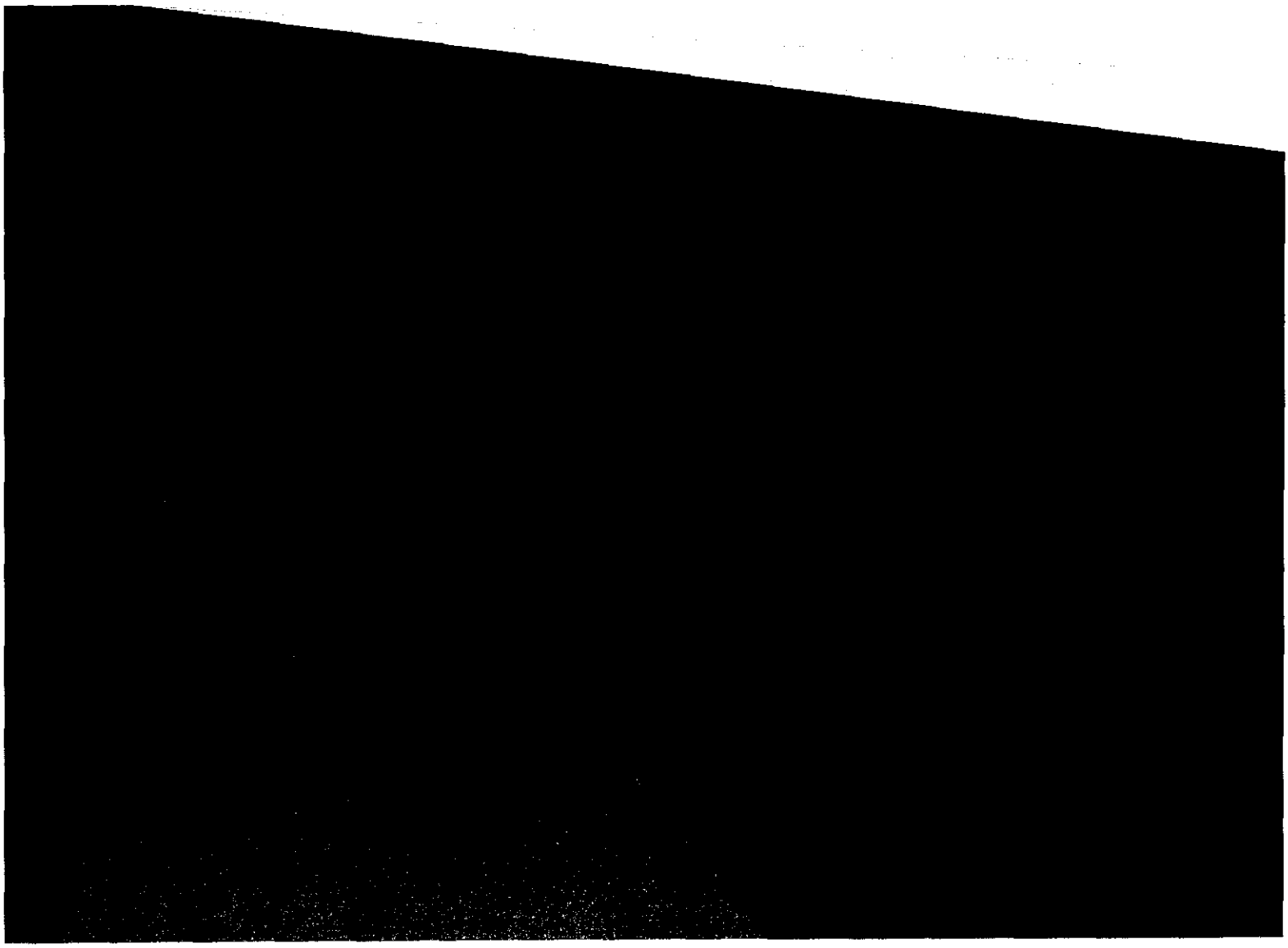
TALENT • HEALTH • RETIREMENT • INVESTMENTS

MERCER

2015 HEALTH AND WELFARE BENEFIT PLAN RENEWAL REPORT

CLACKAMAS COUNTY

OCTOBER 15, 2014



MARSH & McLENNAN COMPANIES

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Summary

The Clackamas County General County and Peace Officers Association (POA) 2015 health and welfare benefit plans renewal decisions are outlined in this report. The Providence and Kaiser medical/prescription drug plans had legislatively required contract changes.

After reviewing the presented plan options, the Benefit Review Committee (BRC) elected to renew all the General County medical/prescription drug plans with a few optional benefit changes in addition to the legislatively required changes. The BRC elected to make no benefit changes to the Moda dental plans. The BRC also opted to carve vision out of the Providence medical plans and add a stand-alone VSP option. The accepted plan design changes are described in detail later in this report.

The POA will renew all the POA medical/pharmacy plans with one optional benefit change in addition to the legislatively required changes. Plan changes were made to the Moda dental plan. The POA will carve vision out of the Providence medical plans and add a stand-alone vision option with VSP. The accepted plan design changes are described in detail later in this report.

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

	Rates PEPM		
	2014	2015	% Change
Medical/Prescription/Vision Plans			
Providence Health Plan – General County[1]			
Personal Option 20/20/1200 $250 Common Deductible (includes VSP vision)			
Employee Only	$629.42	$609.93	
Employee + Spouse	1,258.92	1,219.92	
Employee + Children	1,132.94	1,100.75	
Employee + Family	1,888.27	1,833.37	
Composite	1,387.19	1,346.00	**-3.0%**
Open Option 15/10/30/2000 $250 Common Deductible (includes VSP vision)			
Employee Only	$639.96	$627.17	
Employee + Spouse	1,279.99	1,254.42	
Employee + Children	1,151.91	1,131.80	
Employee + Family	1,919.88	1,885.11	
Composite	1,400.94	1,375.00	**-1.9%**
Providence Health Plan – POA[1]			
Personal Option 15/0/1000 (includes VSP vision)			
Employee Only	$665.80	$636.15	
Employee + Spouse	1,331.69	1,272.38	
Employee + Children	1,198.42	1,147.05	
Employee + Family	1,997.41	1,910.91	
Composite	1,652.19	1,580.38	**-4.3%**
Open Option 10/0/20/2000 $50 Common Deductible (includes VSP vision)			
Employee Only	$684.61	$648.32	
Employee + Spouse	1,369.31	1,296.72	
Employee + Children	1,232.28	1,168.96	
Employee + Family	2,053.84	1,947.42	
Composite	1,682.29	1,594.74	**-5.2%**
Kaiser Permanente HMO – General County (with hearing aids)[1]			
Employee Only	$631.87	$629.60	
Employee + Spouse	1,263.74	1,259.20	
Employee + Children	1,137.36	1,133.28	
Employee + Family	1,895.60	1,888.80	
Composite	1,375.24	1,370.31	**-0.4%**
Kaiser Permanente HMO – POA[1]			
Employee Only	$629.68	$627.42	
Employee + Spouse	1,259.37	1,254.83	
Employee + Children	1,133.43	1,129.35	
Employee + Family	1,889.05	1,882.25	
Composite	1,472.76	1,467.46	**-0.4%**

	Rates PEPM		
	2014	**2015**	**% Change**
Providence Retirees – $1000 Deductible[1]			
Retiree Only	$581.78	$528.24	**-9.2%**
Retiree + Spouse	1,163.64	1,056.55	
Retiree + Children	1,047.19	950.82	
Retiree + Family	1,745.35	1,584.73	
Kaiser Permanente Retirees – General County $1000 Deductible[1]			
Retiree Only	$474.90	$473.19	**-0.4%**
Retiree + Spouse	949.80	946.37	
Retiree + Children	854.83	851.73	
Retiree + Family	1,424.75	1,419.60	
Kaiser Permanente Retirees – POA $1000 Deductible[1]			
Retiree Only	$474.96	$473.25	**-0.4%**
Retiree + Spouse	949.92	946.49	
Retiree + Children	854.83	851.84	
Retiree + Family	1,424.93	1,419.78	
Kaiser Permanente Medicare Retirees[1]			
Retiree Only (GC)	$346.30	$344.58	**-0.5%**
Retiree Only (POA)	$340.74	$339.03	**-0.5%**

Vision Plan

VSP

General County			
12/12/12; $10/$30 copay; $130/$70 allowance	Providence	VSP	
Employee Only	$11.32	$8.57	
Employee + Spouse	22.64	17.13	
Employee + Children	20.38	18.33	
Employee + Family	33.96	29.29	
Composite	25.00	21.00	**-16.0%**
POA			
12/12/24; $10 copay; $130 allowance	Providence	VSP	
Employee Only	$7.54	$5.86	
Employee + Spouse	15.08	11.72	
Employee + Children	13.57	12.54	
Employee + Family	22.62	20.03	
Composite	19.00	16.00	**-15.8%**

	Rates PEPM		
	2014	2015	% Change
Dental Plans			
Moda (formerly ODS)[2]			
Administration	$6.02	$6.10	**1.3%**
Incentive Plan - General County			
Employee Only	$76.00	$74.00	
Employee + Spouse	153.00	149.00	
Employee + Children	108.00	105.00	
Employee + Family	185.00	180.00	
Composite	145.00	141.00	**-2.8%**
Incentive Plan - POA			
Employee Only	$74.00	$70.00	
Employee + Spouse	148.00	139.00	
Employee + Children	105.00	99.00	
Employee + Family	179.00	169.00	
Composite	150.00	141.00	**-6.0%**
50% Plan – General County Only			
Employee Only	$36.00	$30.00	
Employee + Spouse	71.00	59.00	
Employee + Children	50.00	41.00	
Employee + Family	84.00	69.00	
Composite	69.00	57.00	**-17.4%**
Preventive Plan – General County Only			
Employee Only	$72.00	$79.00	
Employee + Spouse	145.00	160.00	
Employee + Children	104.00	114.00	
Employee + Family	176.00	194.00	
Composite	136.00	149.00	**9.6%**
Kaiser Permanente[1]			
Employee Only	$85.95	$90.99	
Employee + Spouse	170.18	180.16	
Employee + Children	118.61	125.57	
Employee + Family	203.70	215.64	
General County Composite	161.34	170.80	**5.9%**

	Rates PEPM		
	2014	2015	% Change
Life and AD&D – MetLife			
Basic Life (Rate per $1,000 benefit)			
Non-represented – General County Only	$0.211	$0.211	**0.0%**
Represented – General County and POA	0.197	0.197	**0.0%**
Group Universal Life	Age rated	Age rated	**0.0%**
Dependent Life per Employee (Rate per Family)			
$5,000 per Dependent – General County	$2.39	$2.39	**0.0%**
$2,000 per Dependent – POA	0.38	0.38	**0.0%**
Voluntary AD&D – General County Only (Rate per $1,000 benefit)			
Employee Only	$0.040	$0.040	**0.0%**
Employee and Family	0.060	0.060	**0.0%**
LTD – The Standard Insurance			
Self-Insured – General County			
Funding Rate (Rate per $100 covered salary)	$0.15	$0.17	**13.3%**
General Fee (Rate per Employee)	0.32	0.36	**12.5%**
New Claim Fee (Rate per Claim)	334.00	390.00	**16.8%**
Open Claim Fee (Rate per Claim)	16.00	19.00	**18.8%**
Fully Insured – General County			
Base Plan (Rate per $100 Covered Salary)	$0.38	$0.38	**0.0%**
Buy-Up Plan (Rate per $100 Covered Salary)	0.38	0.38	**0.0%**
Fully Insured – Peace Officers			
Base Plan (Rate per $100 Covered Salary)	$0.35	$0.35	**0.0%**
Buy-Up Plan (Rate per $100 Covered Salary)	0.39	0.39	**0.0%**
Employee Assistance Plan (EAP) – The Standard Insurance – General County Only			
General Fee per Employee	$0.10	$0.10	**0.0%**
Flexible Spending Account – Flex Plan – General County Only			
Monthly Fee per Participant	$5.00	$5.00	**0.0%**
LTC – Unum – General County Only			
Monthly Rate per Participant	Age rated	Age rated	**15.0%**

[1]*Rates include the standard 2015 contract changes.*
[2]*The dental composite projection calls for a 1.6% decrease.*

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Medical/Prescription Drug/Vision/Alternative Care Plans

Providence Health Plan

General County

The preliminary proposed 2015 renewal rates provided by Providence Health Plan were reductions of -1.8% for the Open Option and -1.1% for the Personal Option, when compared to 2014 rates.

Providence's initial renewal included required legislative changes. Additionally, Providence modified their standard vision plan through VSP resulting in minor enhancements.

The BRC elected the following plan changes for the 2015 plan year:

- Carved out the vision coverage and moved it to be directly with VSP.
- Lowered the deductible from $500 to $250 annually.
- Removed the fourth quarter carryover provision.

After Mercer negotiation, updated experience and plan design changes the renewal rates provided by Providence Health Plan came in at a -1.9% for the Open Option and -3.0% for the Personal Option, after adding vision direct with VSP.

Providence's underwriting worksheet for their renewal is included in **Exhibit A** for reference.

Exhibit B(1) contains the required 2015 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2015.

See **Exhibit C** for the Providence 2015 General County benefit summaries.

The 2015 premium rates are shown below as a per employee per month (PEPM), and include the required contract changes, and PPACA fees for the plans:

Personal Option 20/20/1200 $250 Common Deductible

	Medical/ Prescription	Alternative Care	Total
Actives, Job Share, COBRA[1], & Early Retiree			
Employee Only	$593.16	$8.20	$601.36
Employee + Spouse	1,186.39	16.40	$1,202.79
Employee + Children	1,067.66	14.76	$1,082.42
Employee + Family	1,779.48	24.60	$1,804.08
Composite			$1,325.00

Open Option 15/10/30/2000 $250 Common Deductible with Hearing Aids

	Medical/ Prescription	Alternative Care	Hearing Aids $1,500	Total
Actives, Job Share, COBRA[1], & Early Retiree				
Employee Only	$599.70	$11.45	$7.45	$618.60
Employee + Spouse	1,199.49	22.90	14.90	1,237.29
Employee + Children	1,079.45	20.61	13.41	1,113.47
Employee + Family	1,799.12	34.35	22.35	1,855.82
Composite				$1,354.00

Peace Officers

The preliminary proposed 2015 renewal rates provided by Providence Health Plan were reductions of -2.3% for the Open Option and -1.5% for the Personal Option, when compared to 2014 rates.

Providence's initial renewal included required legislative changes. Additionally, Providence modified their standard vision plan through VSP resulting in minor enhancements.

The POA elected the following plan changes for the 2015 plan year:

- Carved out vision coverage and moved it direct with VSP.

After Mercer negotiation, updated experience and plan design changes the renewal rates provided by Providence Health Plan came in at a -5.2% for the Open Option and -4.3% for the Personal Option.

Providence's underwriting worksheet for their final renewal is included in **Exhibit A** for reference.

The standard 2015 contract changes summary for grandfathered plans in **Exhibit B(2)** apply to the POA plans. The change to a stand-alone vision plan through VSP does not apply to the POA plans.

See **Exhibit C** for the Providence 2015 POA benefit summaries.

[1] COBRA participants are charged an additional 2% administrative fee as allowed by law, which is not included in these rates.

The 2015 premium rates are shown below as PEPM, and include the required contract changes, and PPACA fees for the plans:

Personal Option 15/0/1000

	Medical/ Prescription	Alternative Care	Total
Actives, Job Share, COBRA[1], & Early Retiree			
Employee Only	$625.77	$4.52	$630.29
Employee + Spouse	1,251.62	9.04	1,260.66
Employee + Children	1,126.37	8.14	1,134.51
Employee + Family	1,877.32	13.56	1,890.88
Composite			1,564.07

Open Option 10/0/20/2000 $50 Common Deductible

	Medical/ Prescription	Alternative Care	Total
Actives, Job Share, COBRA[1], & Early Retiree			
Employee Only	$637.94	$4.52	$642.46
Employee + Spouse	1,275.96	9.04	1,285.00
Employee + Children	1,148.28	8.14	1,156.42
Employee + Family	1,913.83	13.56	1,927.39
Composite			1,578.71

Retirees – General County and 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.

Alternatively, the County also offers a $1,000 deductible plan for early retirees and COBRA participants. The County accepted Providence's proposed rate decrease of -9.2%.

Exhibit B contains the standard 2015 contract changes for grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2015 early retiree benefit summaries.

[1] COBRA participants are charged an additional 2% administrative fee as allowed by law, which is not included in these rates.

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

Providence's initial renewal included required legislative changes.

The County elected the following plan changes for the 2015 plan year:

- Removed the fourth quarter carryover provision.

The 2015 premium rates for the current $1,000 Deductible plan are shown below as PEPM, and include the required contract changes and PPACA for the plans:

	Medical/ Prescription	Alternative Care	Total
Employee Only	$525.13	$3.11	$528.24
Employee + Spouse	1,050.33	6.22	1,056.55
Employee + Children	945.22	5.60	950.82
Employee + Family	1,575.40	9.33	1,584.73

Medicare-Eligible retirees (age 65 and older) are eligible for the Medicare Advantage plan, Medicare Align (previously "Medicare Extra"). Providence no longer offers the Supplement Plan F. The 2015 benefit summary is included in **Exhibit C.**

The County accepted Providence's rate increase of 13.1%. The 2015 premium rate for the Providence Medicare Align plan is shown below as a PEPM:

Medicare Align Plan

Medicare Align With Prescription Drug	$276.00

Kaiser Permanente

General County and Peace Officers

Kaiser initially proposed an overall 0.4% decrease to the 2015 premium rates.

The BRC and POA *did not elect to make benefit changes* to these plans. The County renewed the medical, vision, and prescription drug plans with Kaiser Permanente effective January 1, 2015.

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

Exhibit E contains the 2015 contract changes provided by Kaiser. The BRC and POA accepted *the proposed 2015 benefit and administrative clarifications* applicable to grandfathered plans.

See **Exhibit F** for the Kaiser 2015 benefit summaries.

The 2015 premium rates are shown below as a per employee per month (PEPM), and include the required contract changes and PPACA fees for the plans:

Medical/Prescription Drug/Vision Plans

General County	
Employee Only	$629.60
Employee + Spouse	1,259.20
Employee + Children	1,133.28
Employee + Family	1,888.80
Composite	1,370.31

Peace Officers Association	
Employee Only	$627.42
Employee + Spouse	1,254.83
Employee + Children	1,129.35
Employee + Family	1,882.25
Composite	1,467.46

Retirees – General County and 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 -0.4% for the General County and POA plans were accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan.

Exhibit E contains the 2015 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2015 benefit summaries.

The 2015 premium rates for the current $1,000 Deductible plan and Medicare plan are shown below as a per employee per month (PEPM). The premiums include the required contract changes and PPACA fees for the plans:

$1,000 Deductible Plan COBRA[1] and Early Retirees	
General County	
Employee Only	$473.19
Employee + Spouse	946.37
Employee + Children	851.73
Employee + Family	1,419.60

[1] COBRA participants are charged an additional 2% administrative fee as allowed by law, which is not included in these rates.

Peace Officers Association	
Employee Only	$473.25
Employee + Spouse	946.49
Employee + Children	851.84
Employee + Family	1,419.78
Medicare (Parts A, B and D)	
Retiree Only (GC)	$344.58
Retiree Only (POA)	$339.03

Vision Plans

Vision Service Plan (VSP)

The County elected to review a stand-alone vision option through a direct relationship with VSP for both General County and POA. Both self-insured and fully insured funding options were reviewed. The stand-alone, fully insured option with VSP would result in a 16% savings over keeping the vision with Providence.

General County

The BRC voted to recommend to the Board that the vision coverage move direct with VSP and remain fully insured. The General County plan would eliminate the elements pediatric vision plan and add coverage for progressive lenses. The proposed rates for the 2015 plan year are provided below:

General County	
Employee Only	$8.57
Employee + Spouse	17.13
Employee + Children	18.33
Employee + Family	29.29
Composite	21.00

POA

Staff also recommended that the POA move direct with VSP and remain fully insured. The proposed rates for the 2015 plan year are provided below:

POA	
Employee Only	$5.86
Employee + Spouse	11.72
Employee + Children	12.54
Employee + Family	20.03
Composite	18.00

The above VSP rates are guaranteed for 24 months. The plan will next renew January 1, 2017.

See **Exhibit H** for the 2015 VSP benefit summaries.

Dental Plans

Moda Health

The Incentive Plan is available to all employees – General County and Peace Officers. The 50 Percent Plan and Preventive Plan are only available to General County employees. All three plans are self-funded and administered by Moda Health (Moda).

The County is entering the second year of a three-year administrative fee guarantee. The administration fee increase for the remainder of the three-year period will be as follows:

Rates per Employee per Month	2015	2016
Administration fee	$6.10	$6.18
% Change	1.35%	1.35%

The County renewed the dental administration services with Moda effective January 1, 2015, with the following plan changes:

- General County will add coverage for athletic mouth guards.
- The POA accepts all proposed benefit and administrative changes, including those previously declined.

There are no additional plan changes.

Exhibit G contains the Moda administrative contract changes for 2015 for General County and POA.

See **Exhibit H** for the 2015 Moda benefit summaries.

Underwriting

Mercer projected a 2015 combined funding decrease of 1.6% for the 2015 self-insured dental plans. The individual plan decreases used for the 2015 plan year are provided in the underwriting calculation in **Exhibit I**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2013, through June 30, 2014. An annual trend factor of 6.0%, an IBNR reserve factor of 10%, and 0% margin were used.

Mercer recommended and the County accepted the 2015 funding rates listed below. The below rates include all plan changes.

Self-Funded Dental Plans: Budgeting Rates per Employee per Month

Incentive Plan – General County	
Employee Only	$74.00
Employee + Spouse	149.00
Employee + Children	105.00
Employee + Family	180.00
Composite	141.00

Incentive Plan – POA	
Employee Only	$70.00
Employee + Spouse	139.00
Employee + Children	99.00
Employee + Family	169.00
Composite	141.00

50% Plan – General County Only	
Employee Only	$30.00
Employee + Spouse	59.00
Employee + Children	41.00
Employee + Family	69.00
Composite	57.00

Preventive Plan – General County Only	
Employee Only	$79.00
Employee + Spouse	160.00
Employee + Children	114.00
Employee + Family	194.00
Composite	149.00

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees – General County and POA. Kaiser proposed a 5.9% increase to the 2014 premium rates.

The BRC and POA did not make any benefit changes for 2015. The County renewed the dental plan with Kaiser Permanente effective January 1, 2015.

Exhibit E contains the 2015 standard contract changes provided by Kaiser, which will be effective January 1, 2015.

See **Exhibit F** for the Kaiser 2015 benefit summaries.

The 2015 premium rates for Kaiser dental plan is shown below as a per employee per month (PEPM), and include the required contract changes for the plans:

Dental Plan

Employee Only	$90.99
Employee + Spouse	180.16
Employee + Children	125.57
Employee + Family	215.64
Composite	170.80

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. MetLife proposed a rate decrease for all plans effective January 1, 2014, with a three-year rate guarantee. The below rates are effective through December 31, 2016. The County renewed the plans with MetLife effective January 1, 2014, with no change in benefits.

A summary of the rates effective January 1, 2014, through December 31, 2016, are as follows:

General County

Basic Life	
Non-Represented Employees	$0.211/$1,000
Represented Employees	$0.197/$1,000
Dependent Life	
$5,000 per spouse/domestic partner or child	$2.39 PEPM
Voluntary Accidental Death and Dismemberment	
Employee	$0.040/$1,000
Employee and Family (spouse/domestic partner or child)	$0.060/$1,000

Basic Life	
Represented Employees	$0.197/$1,000
Dependent Life	
$2,000 per spouse/domestic partner or child	$0.38 PEPM

General County

Group Universal Life (Rates Per $1,000)

Age	Non-Smoker Rates	Smoker Rates
< 30	$0.044	$0.066
30-34	0.049	0.074
35-39	0.062	0.102
40-44	0.096	0.149
45-49	0.164	0.223
50-54	0.270	0.330
55-59	0.424	0.518
60-64	0.641	0.797
65-69	1.186	1.269
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	$0.118	$0.236	$0.354	$0.472	$0.59

Long Term Disability Insurance

The Standard

The County offers three LTD plans through Standard as follows:

- **Base LTD Plans**
  - **General County and POA.** This coverage is provided by the County without contributions from employees. The disability benefit is 60% of the first $3,333 of monthly predisability 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**
  - **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 predisability earnings above $3,333 up to a maximum of $8,333.
  - **Peace Officers.** This plan offers POA employees the option of buying additional disability coverage, equal to 60% of the next $6,667 of monthly predisability earnings above $3,333 up to a maximum of $10,000.

Both buy-up LTD benefit plans for the General County and 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 2015 plan year.

Fees and Premium Rates

The County is entering the first year of a two-year rate guarantee with Standard. The next renewal will be January 1, 2017.

The 2015 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	$0.17 per $100 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	$0.38/$100
Buy-Up – General County	$0.38/$100
Base – Peace Officers	$0.35/$100
Buy-Up – Peace Officers	$0.39/$100

Employee Assistance Plan

The Standard

The County also receives services through an Employee Assistance Program (EAP) from Standard for employees covered by the long term disability plan. The County also purchases EAP coverage for part-time employees who are not covered under the LTD plan. The rate will remain at $0.10 per member per month.

Flexible Spending Account Administrator

Flex-Plan Services

The County uses Flex-Plan Services to provide FSA plans, which are available only to General County employees. Flex-Plan proposed a rate hold for the 2015 plan year. The County renewed these services with Flex-Plan effective January 1, 2015.

The 2015 fees remain the same as the 2014 fees, as follows:

Fees per Participant per Month	
Health Care FSA	$5
Dependent Care FSA	$5

Long Term Care Insurance

Unum

Unum insures the voluntary long term care (LTC) coverage for General County employees. The 2015 rates increase by 15%, effective January 1, 2015. This is the first rate increase since plan inception in 2000.

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Employee Contributions

General County

For represented employees, the County will pay 95% of the renewal composite medical/ prescription/vision rate up to a capped composite amount for represented employees. 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				
Employer	$598.95	$1,196.97	$1,077.29	$1,794.86
Employee	30.47	61.95	55.65	93.41
Providence Open Option				
Employer	608.96	1,216.99	1,095.31	1,824.89
Employee	31.00	63.00	56.60	94.99
Kaiser				
Employer	601.28	1,201.55	1,081.49	1,801.82
Employee	30.59	62.19	55.87	93.78
Medical Opt Out				
Cash Back	65.00	129.00	116.00	193.00
REPRESENTED				
Providence Personal Option				
Employer	561.42	1,190.92	1,064.94	1,820.27
Employee	68.00	68.00	68.00	68.00
Providence Open Option				
Employer	571.45	1,211.48	1,083.40	1,851.37
Employee	68.51	68.51	68.51	68.51
Kaiser				
Employer	564.37	1,196.24	1,069.86	1,828.10
Employee	67.50	67.50	67.50	67.50
Medical Opt Out				
Cash Back	146.00	146.00	146.00	146.00

The County pays 100% of the premium for the Moda Incentive and Preventive dental plans and the Kaiser dental plan. The County removed the dental contribution for all employees. The Moda 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
Moda Constant (50%)				
Nonrepresented				
Cash Back	$46.00	$92.00	$64.00	$110.00
Represented				
Cash Back	89.00	89.00	89.00	89.00
Dental Opt Out				
Nonrepresented				
Cash Back	47.00	93.00	65.00	111.00
Represented				
Cash Back	90.00	90.00	90.00	90.00

Peace Officers

The County pays 95% of the premium for the Providence medical plans. 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	$557.13	$1,193.36	$1,068.03	$1,831.89
Employee	79.02	79.02	79.02	79.02
Providence Open Option				
Employer	568.58	1,216.98	1,089.22	1,867.68
Employee	79.74	79.74	79.74	79.74
Kaiser				
Employer	627.42	1,254.83	1,129.35	1,882.25
Employee	0.00	0.00	0.00	0.00

The County pays 100% of the premium for the Moda 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	90.00	90.00	90.00	90.00

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Exhibits

- Exhibit A – Providence Health Plans Medical Underwriting
- Exhibit B – Providence Health Plans 2015 Contract Changes
  - Exhibit B(1) – Non-Grandfathered
  - Exhibit B(2) – Grandfathered
- Exhibit C – Providence Health Plans Benefit Summaries
- Exhibit D – Kaiser Permanente Medical Underwriting
- Exhibit E – Kaiser Permanente 2015 Contract Changes
- Exhibit F – Kaiser Permanente Benefit Summaries
- Exhibit G – Moda 2015 Contract Changes
- Exhibit H – Moda Benefit Summaries
- Exhibit I – Self-funded Dental Plan Underwriting Calculation
- Exhibit J – VSP Benefit Summaries

EXHIBIT A

Providence Health Plans Medical Underwriting

Account: CLACKAMAS COUNTY - ACTIVE/EARLY RETIREES
Group Number: 100112
Account Executive: D. MINER
Agent Name: JANET LONG
Effective Date: 1/1/2015 - 12/31/2015
Product(s): PE $20 20% $1200 $500 Rxtra $15/$30 w/Ded Carryover CUST
Vision Premium Plan
SA 20/1500 + MT-CUST

Agent commission has been removed from the rates

Rates include domestic partner coverage
Rates Reflect a Tandem Offering
Rates include coverage for elective sterilizations
Rates include coverage for termination of pregnancy

Current Paid Claims Perio	7/1/2013 -	6/30/2014			Chiro./	Health	
Experience Rate Exhibit	Capitation	Medical	Pharmacy	Vision	Alt .Care	Coach	Total
Paid Claims/Capitation	$742,602	$15,102,635	$2,545,360	$312,962	$217,656	$0	$18,921,216
Pharmacy Rebate	n/a	n/a	-$123,195	n/a	n/a	n/a	-$123,195
Benefit Adjustments	-$14,136	-$282,238	-$42,298	$74,581	$773	$0	-$263,319
Adjusted Non-Pooled Claims	$728,467	$14,820,396	$2,379,866	$387,544	$218,429	$0	$18,534,701
Ending Reserve	n/a	$1,020,103	$36,199	$0	$26,250	$0	
Beginning Reserve	n/a	-$1,425,702	-$38,938	-$16,006	$0	$0	
Incurred Claims	$728,467	$14,414,797	$2,377,127	$371,537	$244,679	$0	$18,136,607
Pooled Claims Credit ($150K)	n/a	-$879,727	$0	$0	n/a	n/a	
Net Pooled Claims	$728,467	$13,535,070	$2,377,127	$371,537	$244,679	$0	$17,256,880
Annual Trend	8.40%	8.40%	8.40%	2.00%	10.00%	0.00%	8.29%
Months of Trend	18.0	18.0	18.0	18.0	18.0	18.0	
Trend Factor	1.1286	1.1286	1.1286	1.0301	1.1537	1.0000	
Trended Incurred Claims	$822,155	$15,275,816	$2,682,850	$382,739	$282,283	$0	$19,445,843
Pooling Charge	n/a	$859,399	$0	$0	n/a	n/a	
Trended Incurred Claims adjusted for Pooling		$19,640,220		$382,739	$282,283	$0	$20,305,242
Administration		$1,848,560		$39,295	$29,224	$0	$1,917,079
ACA Health Insurance Provider Fee		$167,360		$3,238	$2,390	$0	$172,988
Portability Adjustment		$0		n/a	n/a	n/a	$0
State High Risk Reinsurance Fee		$170,375		n/a	n/a	n/a	$170,375
Patient-Centered Outcome Research Institute Fee		$7,753		n/a	n/a	n/a	$7,753
ACA High Risk Reinsurance Fee		$146,234		n/a	n/a	n/a	$146,234
Commission: None		$0		$0	$0	$0	$0
Projected Revenue Requirement		$21,980,502		$425,272	$313,897	$0	$22,719,671
Member Months		46,424		45,935	46,124	46,424	46,424
Projected Revenue Requirement (current 12 mos.)		$473.48		$9.26	$6.81	$0.00	$489.55
Factor to adjust Proj Rev Req (curr 12 mos) to new product		1.000		1.000	1.000	0.000	
Projected Revenue Req (curr 12 mos) adjusted to new product		$473.48		$9.26	$6.81	$0.00	$489.55
Projected Revenue Requirement (current 12 mos.)		$473.48		$9.26	$6.81	$0.00	$489.55
Projected Revenue Requirement (prior 12 mos.)		$502.79		$9.21	$6.36	$0.00	$518.36
Projected Revenue Requirement (demographics)		$414.27		$7.02	$5.57	$0.00	$426.86
Credibility Factor (current 12 mos.)		100.00%		50.00%	50.00%	0.00%	100.00%
Credibility Factor (prior 12 mos.)		0.00%		0.00%	0.00%	0.00%	0.00%
Credibility Factor (demographics)		0.00%		50.00%	50.00%	100.00%	0.00%
Blended Revenue Requirement PMPM		$473.48		$8.14	$6.19	$0.00	$487.81
Revenue Requirement PMPM		$473.48		$8.14	$6.19	$0.00	$487.81

Current Enrollment:

	Subscribers	Members	Mix	Contract Size	Rate Ratio	Mix x Size	Mix x Ratio
EMPLOYEE	324	324	23.0%	1.000	1.000	0.230	0.230
EE+SPOUSE	342	684	24.3%	2.000	2.000	0.486	0.487
EE+CHILD(REN)	153	422	10.9%	2.758	1.800	0.300	0.196
EE+FAMILY	587	2,346	41.7%	3.997	3.000	1.669	1.252
Total	1,406	3,776	100.0%			2.686	2.165

Single Rate Multiplier · Rate Multiplier 1.240

Renewal Rates:

	Medical/Pharmacy	Vision	Chiro/Alt	Health Coach	Total
EMPLOYEE	$587.25	$10.10	$7.68	$0.00	$605.03
EE+SPOUSE	$1,174.57	$20.20	$15.36	$0.00	$1,210.13
EE+CHILD(REN)	$1,057.04	$18.18	$13.82	$0.00	$1,089.04
EE+FAMILY	$1,761.76	$30.30	$23.04	$0.00	$1,815.10

Account:	CLACKAMAS COUNTY - ACTIVE/EARLY RETIREES
Group Number:	100112
Account Executive:	D. MINER
Agent Name:	JANET LONG
Effective Date:	1/1/2015 - 12/31/2015
Product(s):	PE $20 20% $1200 $500 Rxtra $15/$30 w/Ded Carryover CUST
	Vision Premium Plan
	SA 20/1500 + MT-CUST

Agent commission has been removed from the rates

Rates include domestic partner coverage
Rates Reflect a Tandem Offering
Rates include coverage for elective sterilizations
Rates include coverage for termination of pregnancy

Prior Paid Claims Period:	7/1/2012 -	6/30/2013			Chiro./	Health	
Experience Rate Exhibit	**Capitation**	**Medical**	**Pharmacy**	**Vision**	**Alt .Care**	**Coach**	**Total**
Paid Claims Period: 201207	201306						
Paid Claims/Capitation	$729,772	$16,841,912	$2,466,084	$265,166	$222,783	$0	$20,525,717
Pharmacy Rebate	n/a	n/a	-$119,358	n/a	n/a	n/a	-$119,358
Benefit Adjustments	-$25,845	-$658,296	-$41,972	$104,564	-$11,550	$0	-$633,100
Adjusted Non-Pooled Claims	$703,927	$16,183,616	$2,304,753	$369,730	$211,233	$0	$19,773,259
Ending Reserve	n/a	$1,425,702	$38,938	$16,006	$0	$0	
Beginning Reserve	n/a	-$1,118,448	-$28,115	-$16,199	$0	$0	
Incurred Claims	$703,927	$16,490,870	$2,315,577	$369,537	$211,233	$0	$20,091,144
Pooled Claims Credit ($150K)	n/a	-$2,007,525	$0	$0	n/a	n/a	
Net Pooled Claims	$703,927	$14,483,344	$2,315,577	$369,537	$211,233	$0	$18,083,619
Annual Trend	6.40%	6.40%	6.40%	2.00%	10.00%	0.00%	6.36%
Months of Trend	30	30	30	30	30	30	
Trend Factor	1.1678	1.1678	1.1678	1.0508	1.2691	1.0000	
Trended Incurred Claims	$822,019	$16,913,089	$2,704,041	$388,292	$268,067	$0	$21,095,508
Pooling Charge	n/a	$877,536	$0	$0	n/a	n/a	
Trended Incurred Claims adjusted for Pooling		$21,316,685		$388,292	$268,067	$0	$21,973,044
Administration		$2,004,421		$39,865	$27,752	$0	$2,072,039
ACA Health Insurance Provider Fee		$181,470		$3,285	$2,270	$0	$187,025
Portability Adjustment		$0		n/a	n/a	n/a	$0
State High Risk Reinsurance Fee		$173,970		n/a	n/a	n/a	$173,970
Patient-Centered Outcome Research Institute Fee		$7,916		n/a	n/a	n/a	$7,916
ACA High Risk Reinsurance Fee		$149,321		n/a	n/a	n/a	$149,321
Commission: None		$0		$0	$0	$0	$0
Projected Revenue Requirement		$23,833,784		$431,442	$298,089	$0	$24,563,315
Member Months		47,403		46,847	46,838	47,403	47,403
Projected Revenue Requirement (prior 12 mos.)		$502.79		$9.21	$6.36	$0.00	$518.36
Factor to adjust Proj Rev Req (prior 12 mos) to new product		1.000		1.000	1.000	0.000	
Projected Revenue Req (prior 12 mos) adjusted to new product		$502.79		$9.21	$6.36	$0.00	$518.36

EXHIBIT B

Providence Health Plans 2015 Contract Changes

Exhibit B(1) – Non-Grandfathered Plans (General County)

PROVIDENCE Health Plan

Plan Changes for Clackamas County from 1/2014 to 1/2015

Applies to Non-Grandfathered General County renewing 1/1/2015

The following changes have been filed with the State of Oregon and are pending approval at this time. Upon approval, a final list will be provided for your review.

Periodic Health Exams/Well Baby Care

We're giving our members greater flexibility in choosing their providers. Periodic Health Exams and Well Baby Care will now be covered when received from **any** provider as long as these services are within the licensed provider's scope of practice. Previously these services were only covered when received by a Personal Physician/Provider (PPP).

Autism Treatment

With studies focusing attention on increasing rates of autism, Providence is stepping forward with new benefits in our plans. With pre-authorization, coverage is now available for Applied Behavioral Analysis for treating autism spectrum disorders.[1]

Diabetes During Pregnancy

Providence complements its array of existing maternity/newborn/baby services with coverage in full for diabetes services, medications and supplies during pregnancy through six weeks postpartum, when received from in-network providers.

Additional Vision Plan Features and Options

Our supplemental vision offerings are consistently popular with employers and their employees, and we've made changes to provide additional benefits and greater choice.

Coverage for progressive lenses is added to all plans (except "exam only" plans), subject to a $50 copay.

3 new riders are added that include a $130 pediatric frame and contact allowance. This addition means employees now have the choice of a plan with any pediatric frame/contact from the Otis & Piper Eyewear collection regardless of price, or a plan allowing any pediatric frame/contact with a $130 allowance.

Note: Vision exclusions are moved from the benefit summary to the handbook to be consistent with other exclusions.

No Wait Period for Transplants

The 24 month wait period for transplants has been eliminated. This has been added by contract amendment for all groups that renewed on or after 1/1/2014.

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[1] Limitations apply, covered services must be medically necessary and meet plan criteria.

Oregon Selling Service Area Expansion
To better serve our customers, our service area in has been expanded to encompass the entire state of Oregon (as well as Clark, Skamania, and Klickitat counties in Washington).

Deductible Carryover Removed
In order to provide more cost-effective premiums for our plans, our standard contract changes remove the carryover of any funds applied to the deductible during the 4th quarter of the current calendar year to the next calendar year. As described in the renewal summary, our renewal proposal assumes the County will retain the 4th quarter deductible carryover.

Chiropractic Manipulation and Acupuncture
To make our benefits easy to understand and utilize, chiropractic manipulation and acupuncture services will now be offered as a separate rider, with the option to also include massage therapy, a popular treatment for many providers and members. Previously a $500 benefit was embedded in the medical plan with the option to buy up or exclude this benefit.

Note that the health plan deductible does not apply to this benefit and any related copays or coinsurance funds related to this rider do not apply to the medical out-of-pocket maximum, except when the rider is combined with an HSA Qualified plan.

All references to "spinal manipulation" are changed to "chiropractic manipulation".

Additional Cost Tier Services – Choice and Connect Plans Only
For Choice and Connect plans only, coinsurance will apply in addition to the in-network copay. The copay for sinus surgery changes from $500 to $100 plus coinsurance.

Sleep Studies
There are often simple but effective methods for dealing with sleep issues. To help ensure the most appropriate treatment regimen is applied to each situation, prior authorization for a sleep study is now required. This will be added to the benefit summaries under Diagnostic Services.

Improving Clarity in Terminology

All references to "in-plan" and "out-of-plan" are changed to "in-network" and "out-of-network".

Coordination of Benefits (COB)
As required by the Oregon Insurance Division, individual plans are added to the definition of "plan" for coordination of benefit purposes. This applies to groups with grandfathered and non-grandfathered plans. So for covered employees who also have

their own separate individual health plan, employers must coordinate benefits between the two plans.

Note: Groups with collective bargaining agreements (CBAs) have the option of delaying implementation until the first renewal following the expiration of their current CBA. Written confirmation is required with renewal decisions to delay implementation, along with the CBA expiration date.

End Stage Renal Disease (ESRD)
For individuals with ESRD and separate Medicare coverage, payment parameters for coordination of benefits between their Providence plan and their Medicare plan will be added to simplify administration.

Exhibit B(2) – Grandfathered Plans (POA)

PROVIDENCE
Health Plan

Plan Changes for Clackamas County from 1/2014 to 1/2015

Applies to Grandfathered POA renewing 1/1/2015

The following changes have been filed with the State of Oregon and are pending approval at this time. Upon approval, a final list will be provided for your review.

Autism Treatment

With studies focusing attention on increasing rates of autism, Providence is stepping forward with new benefits in our plans. With pre-authorization, coverage is now available for Applied Behavioral Analysis for treating autism spectrum disorders.[1]

No Wait Period for Transplants

The 24 month wait period for transplants has been eliminated. This has been added by contract amendment for all groups that renewed on or after 1/1/2014.

Oregon Selling Service Area Expansion

To better serve our customers, our service area in has been expanded to encompass the entire state of Oregon (as well as Clark, Skamania, and Klickitat counties in Washington).

Sleep Studies

There are often simple but effective methods for dealing with sleep issues. To help ensure the most appropriate treatment regimen is applied to each situation, prior authorization for a sleep study is now required.

Vision Riders

Our supplemental vision offerings are consistently popular with employers and their employees, and we've made changes to provide additional benefits and greater choice.

Coverage for progressive lenses is added to all plans (except "exam only" plans), subject to a $50 copay.

3 new riders are added that include a $130 pediatric frame and contact allowance. This addition means employees now have the choice of a plan with any pediatric frame/contact from the Otis & Piper Eyewear collection regardless of price, or a plan allowing any pediatric frame/contact with a $130 allowance.

Note: Vision exclusions are moved from the benefit summary to the handbook to be consistent with other exclusions.

[1] Limitations apply, covered services must be medically necessary and meet plan criteria.

Improving Clarity in Terminology
All references to "in-plan" and "out-of-plan" are changed to "in-network" and "out-of-network".

Coordination of Benefits (COB)
As required by the Oregon Insurance Division, individual plans are added to the definition of "plan" for coordination of benefit purposes. This applies to groups with grandfathered and non-grandfathered plans. So for covered employees who also have their own separate individual health plan, employers must coordinate benefits between the two plans.

Note: Groups with collective bargaining agreements (CBAs) have the option of delaying implementation until the first renewal following the expiration of their current CBA. Written confirmation is required with renewal decisions to delay implementation, along with the CBA expiration date.

End Stage Renal Disease (ESRD)
For individuals with ESRD and separate Medicare coverage, payment parameters for coordination of benefits between their Providence plan and their Medicare plan will be added to simplify administration.

EXHIBIT C

Providence Health Plans Benefit Summaries

Your Benefit Summary

Personal Option Plan

Clackamas County - General County Employees

PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
$20	20% coinsurance (after deductible)	$1,200 per person $2,400 per family (2 or more)	$250 per person $500 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- Prior authorization is required for some services.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- View a list of EPO network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Personal Option Plan Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services
✓ No deductible needs to be met prior to receiving this service	Copay or Coinsurance (from in-network providers only)
Preventive Care	
• Periodic health exams and well-baby care	Covered in full✓
• Vision and hearing screenings for children under 18	Covered in full✓
• Routine immunizations and shots	Covered in full✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓
• Mammograms	Covered in full✓
• Colonoscopy; sigmoidoscopy	Covered in full✓
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓
Physician / Provider Services	
• Office visits	$20 / visit✓
• Office visits to alternative care providers (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	$20 / visit✓
• Allergy shots, serums, infusions and injectable medications	$20 / visit✓
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Diagnostic Services	
• X-ray and lab services	Covered in full✓
• High-tech imaging services (such as PET, CT or MRI)	Covered in full✓
• Sleep studies	Covered in full✓
Emergency and Urgent Services	
• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$20 / visit✓
• Emergency medical transportation (air and/or ground)	20%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Outpatient Services	
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	$20 / visit✓
Maternity Services	
• Prenatal care	Covered in full✓
• Delivery and postnatal services	$150 / delivery✓
• Inpatient hospital/facility services	20%
• Routine newborn nursery care	20%✓
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%✓
• Diabetes supplies (lancets, test strips and needles)	20%✓
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	20%✓
Mental Health and Substance Abuse (To initiate services, call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient and residential services	20%
• Day treatment, intensive outpatient, and partial hospitalization services	20%
• Applied behavior analysis (limited to 25 hours per week)	20%
• Outpatient provider visits	$20 / visit✓
Home Health and Hospice	
• Home health care	20%
• Hospice care	Covered in full✓

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-Network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

Personal Physician/Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved, your in-network provider will request prior authorization for these services.

Contact us
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: **503-574-7500**
All other areas: **800-878-4445**
TTY: **711**

Have questions about your benefits and want to contact us via email? Go to our website at: www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary

Chiropractic Manipulation, Acupuncture and Massage Therapy

PROVIDENCE Health Plan

Clackamas County - General County Employees on a Personal Option Plan

Copay
$20

Maximum Calendar Year Benefit
$2,000 per member

Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at **www.myProvidence.com.**

- With this benefit you have access to in-network qualified practitioners, including chiropractors, acupuncturists and massage therapists, for chiropractic manipulations, acupuncture and massage therapy.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your chiropractic manipulation, acupuncture, and massage therapy benefits

This plan covers chiropractic manipulations, acupuncture and massage therapy when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physician, acupuncturists or massage therapist, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- Routine preventive care in the absence of an illness, injury, or disease is not covered.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to www.ProvidenceHealthPlan.com/providerdirectory or call us.

Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

Acupuncture covered services

- Acupuncture
- Adjunctive therapy which may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture. All adjunctive therapy must be medically necessary for the treatment of neuromusculoskeletal disorders, nausea or pain and provided together with acupuncture services.
- Services may require review for medical necessity.

Massage therapy covered services

- Short-term rehabilitative therapy.
- Services may require review for medical necessity.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your *specific plan.*

Maximum calendar year benefit
The total dollar amount of benefits, and/or visits, that you can receive per calendar year.

Medical Necessity Review
A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

Out-of-Network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

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Your Benefit Summary

Open Option Plan

Clackamas County - General County Employees

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
$15	10% coinsurance (after deductible)	30% coinsurance (after deductible; UCR applies)	$2,000 per person $4,000 per family (2 or more)	$250 per person $500 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the EPO network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Open Option Plan Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	30%✓
• Vision and hearing screenings for children under 18	Covered in full✓	30%✓
• Routine immunizations and shots	Covered in full✓	30%✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	30%✓
• Mammograms	Covered in full✓	30%
• Colonoscopy; sigmoidoscopy	Covered in full✓	30%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits	$15 / visit✓	30%✓
• Office visits to alternative care providers (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	$15 / visit✓	30%✓
• Allergy shots, serums, infusions and injectable medications	10%	30%
• Inpatient hospital visits	10%	30%
• Surgery; anesthesia	10%	30%
Diagnostic Services		
• X-ray and lab services	10%✓	30%
• High-tech imaging services (such as PET, CT or MRI)	10%✓	30%
• Sleep studies	10%✓	30%
Emergency and Urgent Services		
• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit✓	30%✓
• Emergency medical transportation (air and/or ground)	10%	10%
Hospital Services		
• Inpatient/Observation care	10%	30%
• Rehabilitative care (30 days per calendar year)	10%	30%
• Skilled nursing facility (60 days per calendar year)	10%	30%

Open Option Plan Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	10%	30%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	10%	30%
Maternity Services		
• Prenatal care	Covered in full✓	30%
• Delivery and postnatal services	$150 / delivery✓	30%
• Inpatient hospital/facility services	10%	30%
• Routine newborn nursery care	10%✓	30%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	10%✓	30%
• Diabetes supplies (lancets, test strips and needles)	10%✓	30%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	10%✓	30%
Mental Health and Substance Abuse (To initiate services, call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	10%	30%
• Day treatment, intensive outpatient, and partial hospitalization services	10%	30%
• Applied behavior analysis (limited to 25 hours per week)	10%	30%
• Outpatient provider visits	$15 / visit✓	30%✓
Home Health and Hospice		
• Home health care	10%	30%
• Hospice care	Covered in full✓	Covered in full✓

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Common deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible

Common out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-network services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-Network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Personal Physician/Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us
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Your Benefit Summary

Chiropractic Manipulation, Acupuncture and Massage Therapy

PROVIDENCE Health Plan

Clackamas County - General County Employees on an Open Option Plan

Copay
$15

Maximum Calendar Year Benefit
$2,000 per member

Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at **www.myProvidence.com.**

- With this benefit you have access to in-network qualified practitioners, including chiropractors, acupuncturists and massage therapists, for chiropractic manipulations, acupuncture and massage therapy.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your chiropractic manipulation, acupuncture, and massage therapy benefits

This plan covers chiropractic manipulations, acupuncture and massage therapy when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physician, acupuncturists or massage therapist, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- Routine preventive care in the absence of an illness, injury, or disease is not covered.
- *Only one copay is required per date of service, regardless of the number of covered services received during the visit.* You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to www.ProvidenceHealthPlan.com/providerdirectory or call us.

Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

Acupuncture covered services

- Acupuncture
- Adjunctive therapy which may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture. All adjunctive therapy must be medically necessary for the treatment of neuromusculoskeletal disorders, nausea or pain and provided together with acupuncture services.
- Services may require review for medical necessity.

Massage therapy covered services

- Short-term rehabilitative therapy.
- Services may require review for medical necessity.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan.

Maximum calendar year benefit
The total dollar amount of benefits, and/or visits, that you can receive per calendar year.

Medical Necessity Review
A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

Out-of-Network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

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Your Benefit Summary

Hearing Aid

Clackamas County - General County Employees on an Open Option Plan

PROVIDENCE Health Plan

Benefits

Your Providence Health Plan Supplemental Hearing Aid Benefit provides coverage for members age 18 and older who are not covered by the Oregon mandated hearing aid benefit described in your Member Handbook:

- Up to $1,500 per hearing aid, per ear, per three-calendar-year period.

You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your Supplemental Hearing Aid Benefit.

The $1,500 coverage can be applied to the following services:

- Hearing aid assessment, evaluation and audiogram testing
- Hearing aids

Please see your Member Handbook for information regarding Oregon mandated hearing aid benefits.

Using your hearing aid benefits

For the service to be a covered benefit, you must receive all services to obtain a hearing aid from a licensed hearing professional.

- Please submit your itemized receipts suitable for insurance billing purposes to us for reimbursement.
  Submit claims to:

  Providence Health Plan
  Attn: Claims Dept.
  P.O. Box 3125
  Portland, OR 97208-3125

Exclusions

- Replacement parts or batteries
- Replacement of lost or broken hearing aids
- Repair of hearing aids are not covered under this benefit. Repair needs should be discussed with your provider via your warranty period.
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first
- Bone anchored hearing aids

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Your Benefit Summary

Out-of-Area Dependent

Clackamas County - General County Employees

PROVIDENCE Health Plan

What You Pay	Calendar Year Out-of-Pocket Maximum
20% coinsurance	$1,000 per person $2,000 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at **www.myProvidence.com.**

- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- Prior authorization is required for some services.
- Some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Out-of-Area Dependent Benefit Highlights

You pay the following for covered services:

	Coinsurance
Preventive Care	
• Periodic health exams and well-baby care	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations and shots	Covered in full
• Colonoscopy (age 50+)	Covered in full
• Gynecological exams (calendar year) and Pap tests	Covered in full
• Mammograms	Covered in full
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full
Physician / Provider Services	
• Office visits	20%
• Office visits to alternative care providers (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	20%
• Allergy shots, serums, infusions and injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Diagnostic Services	
• X-ray and lab services	20%
• High-tech imaging services (such as PET, CT or MRI)	20%
• Sleep studies	20%
Emergency and Urgent Services	
• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Emergency medical transportation (air and/or ground)	20%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Outpatient Services	
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	20%

Out-of-Area Dependent Benefit Highlights (continued)	Coinsurance
Maternity Services	
• Prenatal care	Covered in full
• Delivery; postnatal care	20%
• Inpatient hospital/facility services	20%
• *Routine newborn nursery care*	20%
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%
• Diabetes supplies (lancets, test strips and needles)	20%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year)	20%
Mental Health and Substance Abuse (To initiate services, call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient and residential services	20%
• Day treatment, intensive outpatient, and partial hospitalization services	20%
• Applied behavior analysis (limited to 25 hours per week)	20%
• Outpatient provider visits	20%
Home Health and Hospice	
• Home health care	20%
• Hospice care	Covered in full

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-Network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. *These amounts do not apply to your out-of-pocket maximums.*

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Your Benefit Summary
Prescription Drug Plan
Clackamas County - General County Employees

PROVIDENCE Health Plan

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 25,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

	Copay or Coinsurance		
Drug Coverage Category	**All Participating and Preferred Retail Pharmacies** (for up to a 30-day supply)	**All Mail Order and Preferred Retail Pharmacies** (for up to a 90-day supply of maintenance prescriptions)	**All Participating Specialty Pharmacies** (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	$15	$15	$15
Brand-name drug	$30	$30	$30
Compounded drug	50%	Does not apply	Does not apply

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If you or your physician request a brand-name drug when a generic is available, you will be responsible for paying the cost difference, in addition to your brand-name drug copay. This cost difference does not apply to your medical plan out-of-pocket maximum.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at www.ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

What you need to know about limitations and exclusions

The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to: www.ProvidenceHealthPlan.com.

Limitations

- All drugs must be Food and Drug Administration (FDA) approved medically necessary, and require by law, a prescription to dispense. Not all FDA approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months after the drug becomes available on the market for Formulary consideration.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
- Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated Specialty Pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty drugs are listed in our Formulary.
- Self-injectible drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and referenced in the formulary.
- Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. You or your Qualified Practitioner can contact us directly to request prior authorization.

Exclusions

- Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of the common cold.
- Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment.
- Drugs or medications delivered, injected or administered for you by a physician, other provider or another trained person.
- Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults.
- Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra® or drugs required for, or as a result of, sexual transformation.
- Drugs used for the treatment of fertility or infertility.
- Fluoride, for members over the age of 10 years old.
- Replacement of lost or stolen medication.
- Drugs used for weight loss or cosmetic purposes.
- Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Over-the-counter (OTC) drugs, medications or vitamins that may be purchased without a provider's written prescription and prescription drugs that are available in an OTC therapeutically similar form.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions.
- Drugs or prescribed medications that are not medically necessary or are not provided according to our medical policy.
- Drugs to stimulate hair growth, including, but not limited to, Rogaine® (i.e., topical minoxidil) or other similar drug preparations.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Drugs that are not FDA approved or designated as "less than effective" by the FDA, also known as a "DESI" drug.
- Drugs placed on prescription-only status as required by state or local law.
- Compounded drugs from bulk powders that are not a component of an FDA-approved drug.
- Vaccines, immunizations and preventative medications solely for the purpose of travel.

Brand-name drug
Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

Coinsurance
The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Compounded drug
The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

Copay
The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

Maintenance drug
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future.

Participating pharmacies
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Contact us
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All other areas: **800-878-4445**
TTY: **711**

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Your Benefit Summary

Personal Option Plan

Clackamas County POA

PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum
$15	Covered in full for most services	$1,000 per person $3,000 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for **myProvidence** at **www.ProvidenceHealthPlan.com/getstarted.**

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan only provides benefits for medically necessary services when provided by a participating physician or provider.
- Some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Personal Option Plan Benefit Highlights

You pay the following for covered services

	Copay or Coinsurance (from participating providers only)
Physician / Provider Services	
• Office visits	$15 / visit
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations; shots	Covered in full
• Maternity services: prenatal	Covered in full
• Maternity services: delivery and postnatal	$150 / delivery
• Allergy shots; serums; injectable medications	$15 / visit
• Inpatient hospital visits	Covered in full
• Surgery; anesthesia	Covered in full
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full
• Mammograms	Covered in full
Hospital Services	
• Inpatient care	Covered in full
• Observation care	Covered in full
• Maternity care	Covered in full
• Routine newborn nursery care	Covered in full
• Rehabilitative care (30 days per calendar year)	Covered in full
• Skilled nursing facility (60 days per calendar year)	Covered in full
Outpatient Diagnostic Services	
• X-ray; lab services	Covered in full
• Imaging services (such as PET, CT, MRI)	Covered in full
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	$100
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit
• Emergency medical transportation	$50

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Other Covered Services	
• Outpatient rehabilitative services (limited to 30 visits per calendar year)	$15 visit
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	Covered in full
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Home health care	$15 / visit
• Hospice care	Covered in full
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)	
-Generic drugs	Covered in full
-Formulary brand-name drugs	Covered in full
-Non-formulary brand-name drugs	Covered in full
Mental Health / Chemical Dependency (To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient, residential services	Covered in full
• Day treatment, intensive outpatient, and partial hospitalization	Covered in full
• Applied behavior analysis (limited to 25 hours per week)	$15 / visit
• Outpatient provider visits	$15 / visit

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

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Your Benefit Summary

Open Option Plan

Clackamas County POA

PROVIDENCE Health Plan

Copay	What You Pay In-Plan	What You Pay Out-of-Plan	Calendar Year Common Out-of-Pocket Maximum (after deductible)	Calendar Year Common Deductible
$10	Covered in full for most services	20% coinsurance (after deductible; UCR applies)	$2,000 per person $6,000 per family (3 or more)	$50 per person $150 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for **myProvidence** at **www.ProvidenceHealthPlan.com/getstarted**.

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Open Option Plan Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then you pay the following for covered services: In-Plan Copay or Coinsurance (after deductible, when you use a participating provider)	Out-of-Plan Copay or Coinsurance (after deductible, when you use a non-participating provider)
Physician / Provider Services		
• Office visits	$10 / visit✓	20%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	20%✓
• Vision and hearing screenings for children under 18	Covered in full✓	20%✓
• Routine immunizations; shots	Covered in full✓	20%✓
• Maternity services: prenatal	Covered in full✓	20%
• Maternity services: delivery and postnatal	$50 / delivery✓	20%
• Allergy shots; serums; injectable medications	Covered in full	20%
• Inpatient hospital visits	Covered in full	20%
• Surgery; anesthesia	Covered in full	20%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	20%✓
• Mammograms	Covered in full✓	20%
Hospital Services		
• Inpatient care	Covered in full	20%
• Observation care	Covered in full	20%
• Maternity care	Covered in full	20%
• Routine newborn nursery care	Covered in full✓	20%
• Rehabilitative care (30 days per calendar year)	Covered in full	20%
• Skilled nursing facility (60 days per calendar year)	Covered in full	20%
Outpatient Diagnostic Services		
• X-ray; lab services	Covered in full✓	20%
• Imaging services (such as PET, CT, MRI)	Covered in full✓	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	20%*	20%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$10 / visit✓	20%✓
• Emergency medical transportation	$50	$50

* Your deductible(s) do not apply to purchases of diabetes supplies.

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services		
• Outpatient rehabilitative services (30 visits per calendar year)	$10 / visit	20%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	$10 / visit	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Home health care	Covered in full	20%
• Hospice care	Covered in full✓	Covered in full✓
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓	Not covered
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	$10✓	Not covered
-Formulary brand-name drugs	$10✓	Not covered
-Non-formulary brand-name drugs	$10✓	Not covered
Mental Health / Chemical Dependency (To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient, residential services	Covered in full	20%
• Day treatment, intensive outpatient, and partial hospitalization	Covered in full	20%
• Applied behavior analysis (limited to 25 hours per week)	$10 / visit✓	20%
• Outpatient provider visits	$10 / visit✓	20%✓

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Common deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-plan or out-of-plan providers, or the combination of both. The following expenses do not apply to an individual or family deductible:
- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays or coinsurance for any supplemental benefits provided by your employer, such as prescription drugs, or routine vision care

Common out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-plan services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Deductible carryover
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

In-plan benefit
The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-plan
Refers to services you receive from a non-participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

Prior authorization
Some services must be pre-approved. In-Plan, your provider will request prior authorization. Out-of-Plan, you are responsible for obtaining prior authorization.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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Your Benefit Summary
Out-of-Area Dependent

Clackamas County POA

PROVIDENCE Health Plan

What You Pay In-Plan	Calendar Year Out-of-Pocket Maximum
20% coinsurance	$1,000 per person $3,000 per family (3 or more)

Important information about your plan

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- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Some services must be prior authorized by us or a penalty will apply. See your Member Handbook for a list of these services.
- Some services and penalities do not apply to out-of-pocket maximums.
- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Out-of-Area Dependent Benefit Highlights

You pay the following for covered services:

	Coinsurance
Physician / Provider Services	
• Office visits	20%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations; shots	Covered in full
• Maternity services: prenatal	Covered in full
• Maternity services: delivery and postnatal	20%
• Allergy shots; serums; injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full
• Mammograms	Covered in full
Hospital Services	
• Inpatient care	20%
• Observation care	20%
• Maternity care	20%
• Routine newborn nursery care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Outpatient Diagnostic Services	
• X-ray; lab services	20%
• Imaging services (such as PET, CT, MRI)	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Emergency medical transportation	20%

Out-of-Area Dependent Benefit Highlights (continued)	Coinsurance
Other Covered Services	
• Outpatient rehabilitative services (30 visits per calendar year)	20%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Home health care	20%
• Hospice care	Covered in full
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)	
-Generic drugs	$10
-Formulary brand-name drugs	$50
-Non-formulary brand-name drugs	$100
Mental Health / Chemical Dependency (To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient, residential services	20%
• Day treatment, intensive outpatient, and partial hospitalization	20%
• Applied behavior analysis (limited to 25 hours per week)	20%
• Outpatient provider visits	20%

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

Prior authorization
Some services must be pre-approved. You are responsible for obtaining prior authorization.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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Your Benefit Summary

Chiropractic Care Plan

Clackamas County - POA Active Employee Plans

PROVIDENCE Health Plan

Copay
$10

Maximum Calendar Year Benefit
$1,500 per member

Important information about your plan

This chiropractic care benefit is offered as an additional option to your medical plan. This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for **myProvidence** at www.ProvidenceHealthPlan.com/getstarted.

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your chiropractic care benefit

This plan covers chiropractic care services when they are:

- Received from a participating licensed chiropractic physician who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- While you don't need a physician's referral to see a chiropractic provider, you must see a Providence Health Plan participating provider. To find a participating provider in your area, go to www.ProvidenceHealthPlan.com/providerdirectory or call us.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- *Routine preventive care in the absence of an illness, injury, or disease is not covered.*

Using non-participating providers

- In rare circumstances, our national network may not have a participating provider in your area. If this occurs, please contact our authorizing agent at 1-800-678-9133. They will assist you in finding a provider.

What is covered

Benefits for outpatient chiropractic services include:

- Office visits;
- Manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations;
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are medically necessary for the treatment of neuromusculoskeletal disorders;
- Related diagnostic X-rays and laboratory services.
- Services may require review for medical necessity.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Maximum calendar year benefit
The total dollar amount of benefits that you can receive, per calendar year.

Medical Necessity Review
A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

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Your Benefit Summary
Prescription Drug Plan
Clackamas County POA

PROVIDENCE Health Plan

Important information about your plan
This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 25,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copays, coinsurance and any difference in costs for prescription drugs do not apply to your calendar year medical plan out-of-pocket maximums or deductibles.

	Copay or Coinsurance		
Drug Coverage Category	**All Participating and Preferred Retail Pharmacies** (for up to a 30-day supply)	**All Mail Order and Preferred Retail Pharmacies** (for up to a 90-day supply of maintenance prescriptions)	**All Participating Specialty Pharmacies** (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	$10	$10	$10
Brand-name drug	$15	$15	$15
Compounded drug	50%	Does not apply	Does not apply

What you need to know about drug coverage categories
- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If you or your physician request a brand-name drug when a generic is available, you will be responsible for paying the cost difference, in addition to your brand-name drug copay. This cost difference does not apply to your medical plan out-of-pocket maximum.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

Using your prescription drug benefit
- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at www.ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary
- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail
- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

What you need to know about limitations and exclusions

The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to: www.ProvidenceHealthPlan.com.

Limitations

- All drugs must be Food and Drug Administration (FDA) approved medically necessary, and require by law, a prescription to dispense. Not all FDA approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months after the drug becomes available on the market for Formulary consideration.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
- Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated Specialty Pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty drugs are listed in our Formulary.
- Self-injectible drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and referenced in the formulary.
- Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. You or your Qualified Practitioner can contact us directly to request prior authorization.

Exclusions

- Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of the common cold.
- Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment.
- Drugs or medications delivered, injected or administered for you by a physician, other provider or another trained person.
- Drugs prescribed by naturopathic physicians (N.D.).
- Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults.
- Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra® or drugs required for, or as a result of, sexual transformation.
- Drugs used for the treatment of fertility or infertility.
- Fluoride, for members over the age of 10 years old.
- Replacement of lost or stolen medication.
- Drugs used for weight loss or cosmetic purposes.
- Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Over-the-counter (OTC) drugs, medications or vitamins that may be purchased without a provider's written prescription and prescription drugs that are available in an OTC therapeutically similar form.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions.
- Drugs or prescribed medications that are not medically necessary or are not provided according to our medical policy.
- Drugs to stimulate hair growth, including, but not limited to, Rogaine® (i.e., topical minoxidil) or other similar drug preparations.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Drugs that are not FDA approved or designated as "less than effective" by the FDA, also known as a "DESI" drug.
- Drugs placed on prescription-only status as required by state or local law.
- Compounded drugs from bulk powders that are not a component of an FDA-approved drug.
- Vaccines, immunizations and preventative medications solely for the purpose of travel.

Brand-name drug
Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

Coinsurance
The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Compounded drug
The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

Copay
The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

Maintenance drug
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future.

Participating pharmacies
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Contact us
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All other areas: **800-878-4445**
TTY: **711**

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Your Benefit Summary
Open Option Plan
Clackamas County Early Retirees and COBRA Participants

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
$15	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$2,000 per person $4,000 per family (2 or more)	$1,000 per person $2,000 per family (2 or more)

Important information about your plan
This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the EPO network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Open Option Plan Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	50%✓
• Vision and hearing screenings for children under 18	Covered in full✓	50%✓
• Routine immunizations and shots	Covered in full✓	50%✓
• Colonoscopy (age 50+)	Covered in full✓	50%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits	$15 / visit✓	50%✓
• Office visits to alternative care providers (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	$15 / visit✓	50%✓
• Allergy shots, serums, infusions and injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Diagnostic Services		
• X-ray and lab services	30%✓	50%
• High-tech imaging services (such as PET, CT or MRI)	30%✓	50%
• Sleep studies	30%✓	50%
Emergency and Urgent Services		
• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit✓	50%✓
• Emergency medical transportation (air and/or ground)	30%	30%
Hospital Services		
• Inpatient/Observation care	30%	50%
• Rehabilitative care (30 days per calendar year)	30%	50%
• Skilled nursing facility (60 days per calendar year)	30%	50%

Open Option Plan Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	30%	50%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	30%	50%
Maternity Services		
• Prenatal care	Covered in full✓	50%
• Delivery and postnatal services	$100 / delivery✓	50%
• Inpatient hospital/facility services	30%	50%
• Routine newborn nursery care	30%✓	50%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	30%	50%
• Diabetes supplies (lancets, test strips and needles)	30%✓	50%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	30%	50%
Mental Health and Substance Abuse (To initiate services, call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	30%	50%
• Day treatment, intensive outpatient, and partial hospitalization services	30%	50%
• Applied behavior analysis (limited to 25 hours per week)	30%	50%
• Outpatient provider visits	$15 / visit✓	50%✓
Home Health and Hospice		
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Common deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible

Common out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-network services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-Network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Personal Physician/Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us
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All other areas: **800-878-4445**
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Your Benefit Summary
Chiropractic Manipulation and Acupuncture

PROVIDENCE Health Plan

Copay
$25

Maximum Calendar Year Benefit
$500

Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at **www.myProvidence.com.**

- With this benefit you have access to in-network qualified practitioners, including chiropractors and acupuncturists, for spinal manipulations and acupuncture.
- For members enrolled in a Health Savings Account (HSA) plan, your deductible applies to these benefits and your copayment or coinsurance applies to your plan out-of-pocket maximum. For members on all other plans, your medical plan deductible does not apply to these benefits, and copayment or coinsurance does not apply to your medical plan out-of-pocket maximum.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your chiropractic and acupuncture benefits

This plan covers chiropractic manipulations and acupuncture when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physicians or acupuncturists, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to www.ProvidenceHealthPlan.com/providerdirectory or call us.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- Routine preventive care in the absence of an illness, injury, or disease is not covered.

Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

Acupuncture covered services

- Acupuncture
- Adjunctive therapy which may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture. All adjunctive therapy must be medically necessary for the treatment of neuromusculoskeletal disorders, nausea or pain and provided together with acupuncture services.
- Services may require review for medical necessity.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Maximum calendar year benefit
The total dollar amount of benefits that you can receive, per calendar year.

Medical Necessity Review
A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

Out-of-Network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Your Benefit Summary
Prescription Drug Plan

PROVIDENCE Health Plan

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 25,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

	Copay or Coinsurance		
Drug Coverage Category	**All Participating and Preferred Retail Pharmacies** (for up to a 30-day supply)	**All Mail Order and Preferred Retail Pharmacies** (for up to a 90-day supply of maintenance prescriptions)	**All Participating Specialty Pharmacies** (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	$10	$30	$10
Brand-name drug	50%	50%	50%
Compounded drug	50%	Does not apply	Does not apply

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at www.ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

What you need to know about limitations and exclusions

The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to: www.ProvidenceHealthPlan.com.

Limitations

- All drugs must be Food and Drug Administration (FDA) approved medically necessary, and require by law, a prescription to dispense. Not all FDA approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months after the drug becomes available on the market for Formulary consideration.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
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- Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. You or your Qualified Practitioner can contact us directly to request prior authorization.

Exclusions

- Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of the common cold.
- Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment.
- Drugs or medications delivered, injected or administered for you by a physician, other provider or another trained person.
- Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults.
- Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra® or drugs required for, or as a result of, sexual transformation.
- Drugs used for the treatment of fertility or infertility.
- Fluoride, for members over the age of 10 years old.
- Replacement of lost or stolen medication.
- Drugs used for weight loss or cosmetic purposes.
- Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Over-the-counter (OTC) drugs, medications or vitamins that may be purchased without a provider's written prescription and prescription drugs that are available in an OTC therapeutically similar form.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions.
- Drugs or prescribed medications that are not medically necessary or are not provided according to our medical policy.
- Drugs to stimulate hair growth, including, but not limited to, Rogaine® (i.e., topical minoxidil) or other similar drug preparations.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Drugs that are not FDA approved or designated as "less than effective" by the FDA, also known as a "DESI" drug.
- Drugs placed on prescription-only status as required by state or local law.
- Compounded drugs from bulk powders that are not a component of an FDA-approved drug.
- Vaccines, immunizations and preventative medications solely for the purpose of travel.

Brand-name drug
Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

Coinsurance
The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Compounded drug
The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

Copay
The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

Maintenance drug
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future.

Participating pharmacies
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Contact us
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All other areas: **800-878-4445**
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Your Benefit Summary

Non-Medicare Eligible Retired Employees

Clackamas County

PROVIDENCE Health Plan

Important information about your plan

This Benefit Summary supplements your employer group's health plan to include non-Medicare Retired Employee coverage.

Retired Employee definition

A Retired Employee is a non-Medicare eligible subscriber who retires from employment with the employer.

Retired Employee eligibility

A retiring subscriber is eligible for retiree medical coverage on the date of retirement upon satisfying the eligibility requirements as stated in the Member Handbook and/or the Employer Group Contract.

Retired Employee dependent eligibility

Eligible family dependents of Retired Employees are eligible for coverage when indicated as covered in the Employer/Group Agreement. Please check with your employer to see if your family dependents are eligible for coverage. Eligible family dependents are subject to the eligibility and enrollment requirements as stated in your Member Handbook.

Enrollment

Notification of the subscriber's retirement must be submitted to us by your employer within 60 days of the date of retirement, unless otherwise indicated on your employer's group contract.

Termination of coverage

In addition to the termination provisions stated in your Member Handbook, members who become eligible for Medicare will no longer qualify for coverage under this supplemental benefit. Termination will occur on the earlier of the effective date stated in the Employer/Group Agreement or the last day of the month in which the individual no longer qualifies for this coverage.

Continuation of coverage

Retired employees and their eligible family dependents who qualify for Continuation Coverage are entitled to elect Continuation Coverage under this group contract.

Contact us

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Your Benefit Summary
Men's Elective Sterilization

PROVIDENCE Health Plan

Covered Services

Covered services under this supplemental benefit endorsement include a male Member's elective sterilization (vasectomy). Prior authorization is not required and Members may receive covered services from the provider and/or facility of their choice.

Please review your medical Benefit Summary for your Copayment or Coinsurance amounts. For Members enrolled on a medical plan with In-Plan and Out-of-Plan benefits, elective sterilization Services are covered at the Outpatient Surgery In-Plan Copayment or Coinsurance amount.

For Members enrolled in a Health Savings Account (HSA) plan, your Deductible DOES apply to this benefit.

For Members on all other plans, the medical Deductible, if any, DOES NOT apply to this benefit.

Copayments and coinsurance apply to your medical plan Out-of-Pocket Maximum.

All Covered Services are subject to the specific conditions, duration limitations and all applicable maximums of the Group Contract on a Usual, Customary and Reasonable (UCR) cost basis.

Please note:

Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience does not offer these services at Providence Health & Services facilities. Services are available at other Participating facilities.

Your Benefit Summary

Domestic Partner Plus

Clackamas County

PROVIDENCE Health Plan

Important information about your plan

This Benefit Summary supplements your employer group's health plan and amends your standard domestic partner coverage.

Domestic partner definition

The domestic partner definition found in your Member Handbook is amended to read:

Domestic partner means either of the following:

An Oregon Registered Domestic Partner is a person who is:

1. At least 18 years of age;
2. Has entered into a domestic partnership with a subscriber of the same sex; and
3. Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

A domestic partner who is not an Oregon Registered Domestic Partner is a person at least 18 years of age who:

1. Shares a close personal relationship with a subscriber such that each is responsible for each other's welfare;
2. Is the subscriber's sole domestic partner;
3. Is not married to any person and does not have another domestic partner;
4. Is not related by blood to the subscriber as a first cousin or nearer;
5. Shares with the subscriber the same regular and permanent residence, with the current intention of doing so indefinitely;
6. Is jointly financially responsible with the subscriber for basic living expenses such as food and shelter;
7. Was mentally competent to consent to contract when the domestic partnership began; and
8. Has provided the required employer documentation establishing that a domestic partnership exists.

- Note: All provisions of your Member Handbook that apply to a spouse shall apply to a domestic partner.

EXHIBIT D

Kaiser Permanente Medical Underwriting

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional
Quote Name: *Plan C15B – Custom subgroups 007, 018, 030*

Region: Northwest
Contract Period: 01/01/2015 – 12/31/2015
Report Period: Mar 2013 through Feb 2014

	Mar13–Feb14
Average Members:	1,511

Rating Month: March 2014
Rating Members: 235

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	***Projected Claims Calculation***					
A1	Paid Claims				$6,960,093	$383.772
A2	– Pooling Credit	Pooling Point:$175,000			(13,104)	(0.723)
A3	+ Pooling Charge				175,738	9.690
A4	Claims Net of Pooling				$7,122,728	*$392.739*
A5	X Incurred Claims Adjustment			1.01930		
A6	X Demographic Change			0.99093		
A7	X Historical Benefit Change			*1.000030*		
A8	Adjusted Claims					$396.699
A9	X Trend Factor	Annual Trend: 6.32%		1.11889		
A10	*Claims based PMPM*	*22.0 Months Midpoint to Midpoint*				$443.863
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$104,308	$443.864
D2	X Future Benefit Change	1.0000		
D3	Adjusted PMPM		$104,308	$443.864
D4	+ Retention		7,591	32.300
D5	+ Other Benefits		2,750	11.700
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		955	4.065
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		902	3.840
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$116,506**	**$495.769**
E	**Capping**	**Increase**		
E1	In-Force Rate		$115,358	$490.885
E2	Premium Requirement without Benefit Change and Underwriter Adj	1.00%	116,506	495.769
E3	Capping Rate	(0.36)%	114,943	489.118
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**(0.36%)**	**114,943**	**489.118**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(0.36)%**	**114,943**	**489.118**
E7	Capping Adjustment		(1,563)	(6.651)

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional
Quote Name: Plan C15C – Custom subgroups 042

Region: Northwest
Contract Period: 01/01/2015 – 12/31/2015
Report Period: Mar 2013 through Feb 2014

	Mar13-Feb14
Average Members:	1,511

Rating Month: March 2014
Rating Members: 2

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,960,093	$383.772
A2	– Pooling Credit	Pooling Point:$175,000			(13,104)	(0.723)
A3	+ Pooling Charge				175,738	9.690
A4	Claims Net of Pooling				$7,122,728	$392.739
A5	X Incurred Claims Adjustment			1.01930		
A6	X Demographic Change			0.99093		
A7	X Historical Benefit Change			1.002730		
A8	Adjusted Claims					$397.770
A9	X Trend Factor	Annual Trend: 6.32%		1.11889		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$445.061
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$890	$445.062
D2	X Future Benefit Change	1.0000		
D3	Adjusted PMPM		$890	$445.062
D4	+ Retention		65	32.300
D5	+ Other Benefits		23	11.700
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		8	4.075
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		8	3.840
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$994**	**$496.977**
E	**Capping**	**Increase**		
E1	In-Force Rate		$1,262	$631.105
E2	Premium Requirement without Benefit Change and Underwriter Adj	(21.25)%	994	496.977
E3	Capping Rate	(0.36)%	1,258	628.833
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**(0.36%)**	**1,258**	**628.833**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(0.36)%**	**1,258**	**628.833**
E7	Capping Adjustment		264	131.856

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional
Quote Name: Plan C15C – Custom subgroups 001, etc.

Region: Northwest
Contract Period: 01/01/2015 – 12/31/2015
Report Period: Mar 2013 through Feb 2014

	Mar13–Feb14
Average Members:	1,511

Rating Month: March 2014
Rating Members: 1,308

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,960,093	$383.772
A2	– Pooling Credit	Pooling Point:$175,000			(13,104)	(0.723)
A3	+ Pooling Charge				175,738	9.690
A4	Claims Net of Pooling				$7,122,728	$392.739
A5	X Incurred Claims Adjustment			1.01930		
A6	X Demographic Change			0.99093		
A7	X *Historical Benefit Change*			1.002730		
A8	Adjusted Claims					$397.770
A9	X Trend Factor	Annual Trend: 6.32%		1.11889		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$445.061
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$582,141	$445.062
D2	X *Future Benefit Change*	1.0000		
D3	Adjusted PMPM		$582,141	$445.062
D4	+ Retention		42,248	32.300
D5	+ Other Benefits		16,154	12.350
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		5,338	4.081
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		5,023	3.840
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$650,904**	**$497.633**
E	**Capping**	**Increase**		
E1	In-Force Rate		$653,731	$499.794
E2	Premium Requirement without Benefit Change and Underwriter Adj	(0.43)%	650,904	497.633
E3	Capping Rate	(0.36)%	651,377	497.995
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**(0.36%)**	**651,377**	**497.995**
E5	X Underwriter Adjustment	1.00001		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(0.36)%**	**651,384**	**498.000**
E7	Capping Adjustment		473	0.362

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059

Product Type: Traditional-Low Deductible
Quote Name: Plan 3C15 - Custom subgroups 059, 063

Region: Northwest
Contract Period: 01/01/2015 - 12/31/2015
Report Period: Mar 2013 through Feb 2014

	Mar13-Feb14
Average Members:	1,511

Rating Month: March 2014
Rating Members: 5

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,960,093	$383.772
A2	- Pooling Credit	Pooling Point:$175,000			(13,104)	(0.723)
A3	+ Pooling Charge				175,738	9.690
A4	Claims Net of Pooling				$7,122,728	$392.739
A5	X Incurred Claims Adjustment			1.01930		
A6	X Demographic Change			0.99093		
A7	X Historical Benefit Change			0.745510		
A8	Adjusted Claims					$295.734
A9	X Trend Factor	Annual Trend: 6.32%		1.11889		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$330.894
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$1,654	$330.895
D2	X Future Benefit Change	1.0000		
D3	Adjusted PMPM		$1,654	$330.891
D4	+ Retention		162	32.300
D5	+ Other Benefits		59	11.700
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		16	3.131
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		19	3.840
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$1,909**	**$381.862**
E	**Capping**	**Increase**		
E1	In-Force Rate		$2,375	$474.900
E2	Premium Requirement without Benefit Change and Underwriter Adj	(19.59)%	1,909	381.866
E3	Capping Rate	(0.36)%	2,366	473.190
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**(0.36%)**	**2,366**	**473.185**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(0.36)%**	**2,366**	**473.185**
E7	Capping Adjustment		457	91.324

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional-Low Deductible
Quote Name: Plan 3C15 - Custom subgroups 058, 060

Region: Northwest
Contract Period: 01/01/2015 - 12/31/2015
Report Period: Mar 2013 through Feb 2014

	Mar13-Feb14
Average Members:	1,511

Rating Month: March 2014
Rating Members: 4

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,960,093	$383.772
A2	- Pooling Credit	Pooling Point:$175,000			(13,104)	(0.723)
A3	+ Pooling Charge				175,738	9.690
A4	Claims Net of Pooling				$7,122,728	$392.739
A5	X Incurred Claims Adjustment			1.01930		
A6	X Demographic Change			0.99093		
A7	X Historical Benefit Change			0.743500		
A8	Adjusted Claims					$294.938
A9	X Trend Factor	Annual Trend: 6.32%		1.11889		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$330.003
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$1,320	$330.004
D2	X Future Benefit Change	1.0000		
D3	Adjusted PMPM		$1,320	$330.000
D4	+ Retention		129	32.300
D5	+ Other Benefits		47	11.700
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		12	3.124
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		15	3.840
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$1,524**	**$380.964**
E	**Capping**	**Increase**		
E1	In-Force Rate		$1,900	$474.960
E2	Premium Requirement without Benefit Change and Underwriter Adj	(19.79)%	1,524	380.968
E3	Capping Rate	(0.36)%	1,893	473.250
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**(0.36%)**	**1,893**	**473.245**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(0.36)%**	**1,893**	**473.245**
E7	Capping Adjustment		369	92.282

EXHIBIT E

Kaiser Permanente 2015 Contract Changes

KAISER PERMANENTE®

2015 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

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 may apply, such as moving to standard benefits. Refer to the Plan Updates 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 2015. 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 and Added Choice® medical plans

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

Benefit changes

- For Traditional, Deductible, and High Deductible Health Plans, the definition of "Usual and Customary Fee" in the *EOC* "Definitions" section has been deleted and replaced with "Allowed Amount." Allowed Amount is based on billed Charges or 160 percent of the Medicare fee, whichever is lower.
- For Deductible and Added Choice Plans, Deductible carry-over has been removed. Charges paid for Services received during the last three months of the previous Calendar Year will no longer count toward the Deductible.
- The "Post-Stabilization Care" *EOC* section has been modified. For all plans, prior authorization for Post Stabilization Care from a Non-Participating Facility or Non-Participating Provider must be obtained no later than 24 hours after any admission, or as soon as reasonably possible. For three tier Added Choice Plans, this also applies when obtaining prior authorization for Post Stabilization Care from PPO Facilities or PPO Providers. Coverage for Post-Stabilization Care at a Non-Participating Facility or a Non-Participating Provider is limited to the Allowed Amount.
- The "Mental Health Services Exclusions and Limitations" *EOC* section has been modified. Treatment for paraphilia diagnostic code 302.9 is excluded from coverage.
- The "Outpatient Prescription Drugs and Supplies" and the "Transplant Services" *EOC* sections have been modified. Post-surgical immunosuppressive drugs are subject to Deductible, Copayment, and/or Coinsurance amounts for the applicable prescription drug tier.
- A "Surrogacy Arrangement" *EOC* section has been added to the "Reductions" *EOC* section. This section provides information about Member obligations to Company in connection with a surrogacy arrangement, including Member obligations to reimburse Company for any Services received, and provides information about who may be financially responsible for any Services received by the baby (or babies).

Benefit clarifications

- Colorectal cancer screening Services and scope insertion procedures have been clarified in each of the *following EOC sections:* "Preventive Care Services," "Benefits for Outpatient Services," and "Outpatient Laboratory X-ray, Imaging, and Special Diagnostic Procedures."
- A "Maternity and Newborn Care" *EOC* section has been added to the "Benefits" *EOC* section to provide a more detailed explanation of maternity benefits.
- The "Mental Health Services" *EOC* section has been modified to update the reference to the Diagnostic and Statistical Manual of Mental Disorders from the 4th edition to the 5th edition (current edition).
- The "*Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures*" *EOC* section has been reformatted for improved readability and alignment with the "Benefit Summary".
- The "Outpatient Prescription Drugs and Supplies" *EOC* section has been modified to clarify existing benefits. Except for specific over-the-counter (OTC) drugs covered under preventive services, nutritional supplements are not covered.
- For Deductible, High Deductible, and Traditional Plans, the custodial Services provision in the "Exclusions" *EOC* section has been modified. We have deleted "Medicare doesn't pay for custodial care" as this wording is not applicable to commercial plans.
- "Certain Exams and Services" in the "Exclusions" *EOC* section has been clarified. We do not exclude Medically Necessary court-ordered Services that are covered under "Chemical Dependency" or "Mental Health Services" in the *EOC* "Benefits" section.

Administrative changes or clarifications

- "Membership Services" in the Benefit Summary and the *EOC* has been replaced by "Member Services" to reflect the updated department name.
- "Spouse" in the *EOC* "Definitions" section has been clarified as the person to whom you are legally married under applicable law.
- The "Other Special Enrollment Events" *EOC* section has been modified to comply with the guaranteed availability provisions of the Affordable Care Act (ACA).
- The "Premium, Eligibility, and Enrollment" *EOC* section has been modified. We have added a new "Special Enrollment Due to a Section 125 Qualifying Event" provision that describes special enrollment information if Group has a Section 125 cafeteria plan.
- The "Certificates of Creditable Coverage" *EOC* section under "Termination of Membership" provision has been deleted. In addition, the "HIPAA Certificates of Creditable Coverage" section of the *Group Agreement* has also been deleted. Issuing certificates of creditable coverage is no longer a requirement.
- The "Notices" section is now a subsection under "Miscellaneous Provisions" in the *Group Agreement* and also includes Company email address for billing and enrollment issues.

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

Benefit changes

- The definition of "Allowed Amount" in the *EOC* "Definitions" section has changed. Allowed Amount is based on billed Charges or 100 percent of the Medicare fee, whichever is lower.

Administrative changes or clarifications

- Throughout the *EOC*, all references to Permanente Advantage have been deleted. Kaiser Foundation Health Plan of the Northwest will provide Tier 2 utilization management and prior authorization services.
- The "Tier 1 Referrals" and "Tier 1 Prior Authorization Review Requirements" *EOC* sections have been modified. A PPO Provider (for three tier Added Choice Plans) or a Non-Participating Provider (for two tier and three tier Added Choice Plans) may refer a Member directly to a Specialist who is a Select Provider, subject to utilization review criteria.

Changes and clarifications that apply to medical benefit riders

Benefit changes

- The "Outpatient Prescription Drug Rider" has been modified. All Deductibles, Copayments, and Coinsurance for prescription drugs and supplies now accumulate to the medical Out-of-Pocket Maximum.
- The "Pediatric Vision Services Exclusions" section within the "Pediatric Vision Services Rider" has been modified to identify lens materials that are not covered.

Benefit clarifications

- The "Alternative Care Services Rider" has been modified. We have moved the "Definitions" and "General Benefit Requirements" sections to the beginning of the rider.
- The "Outpatient Prescription Drug Rider" has been modified to clarify existing benefits. Except for specific over-the-counter (OTC) drugs covered under preventive services, nutritional supplements are not covered.

Administrative changes or clarifications

- The "Outpatient Prescription Drug Rider" has been modified. All references to the Catamaran pharmacy network option have been replaced with the MedImpact pharmacy network.

Changes and clarifications that apply to dental plans

Benefit clarifications

- For Dental Choice PPO Plans, an "Emergency Dental Care and Urgent Dental Care" provision has been added to the "Benefit" *EOC* section.

Administrative changes or clarifications

- "Membership Services" in the Benefit Summary and the *EOC* has been replaced by "Member Services" to reflect the updated department name.
- "Spouse" in the *EOC* "Definitions" section has been clarified as the person to whom you are legally married under applicable law.

- The "Premium, Eligibility, and Enrollment" *EOC* section has been modified. We have added a new "Special Enrollment Due to a Section 125 Qualifying Event" provision that describes special enrollment information if Group has a Section 125 cafeteria plan.
- The "Grievances, Claims, and Appeals" *EOC* section has been revised for more consistency with how we describe grievances, claims and appeals processes for our medical plans.
- The "State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or older in COBRA Groups" under the "Continuation of Membership" section has been deleted. This provision applies to medical plans only.
- The "Litigation Venue" provision under the "Miscellaneous Provisions" section of the *Group Agreement* and *EOC* that specified Multnomah County as the litigation venue has been deleted. Oregon law confers to the courts the discretion to determine the litigation venue.
- The "Notices" section is now a subsection under "Miscellaneous Provisions" in the *Group Agreement* and also includes Company email address for billing and enrollment issues.

Changes and clarifications that apply to all Senior Advantage plans

Changes and clarifications that apply to Senior Advantage plans will be available no earlier than June 2, 2014.

EXHIBIT F

Kaiser Permanente Benefit Summaries

All plans offered and underwritten by Kaiser Foundation Health Plan
of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

Clackamas County 1183 – General County
Oregon Traditional Copayment Plan C15C
January 1, 2015 through December 31, 2015

Out-of-Pocket Maximum (Copayment, and Coinsurance amounts count toward the maximum, unless otherwise noted.)	
For one Member	*$600 per Calendar Year*
For an entire Family	$1,200 per Calendar Year
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	$10
Specialty Care	$10
Urgent Care	$10
Tests (outpatient)	
Preventive tests	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Medications	
Prescription drugs (outpatient)	$10 generic/$20 brand. $0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments.
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$0
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
Inpatient Hospital Services	$0
Hospital Services	
Ambulance Services (per transport)	$75
Emergency department visit	$75 (Waived if admitted)
Inpatient Hospital Services	$0
Outpatient Services (other)	
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Durable medical equipment, external prosthetic devices, and orthotic devices	$0
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$10
Alternative Care	
Alternative care (physician-referred)(limited to 12 visits per Calendar Year)	$10
Alternative care (self-referred)	$10 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.

Vision Services	
Routine eye exam	$10
Vision hardware and optical Services (ages 18 years and younger)	No charge for one pair standard frames and lenses or 6-month supply contact lenses every 24 months.
Vision hardware and optical Services (ages 19 years and older)	Balance after $250 allowance every 24 months
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	
Outpatient Services	$10
Inpatient hospital & residential Services	$0
Mental Health Services	
Outpatient Services	$10
Inpatient hospital & residential Services	$0
Hearing Aids	
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	$0
Hearing aids (ages 19 years and older)	Balance after $1,500 allowance is applied for each hearing aid per ear every three years
Student Out-of-Area Coverage	
Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year; amounts do not count toward the maximum)	20% of the actual fee the provider, facility, or vendor charged for the Service

Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the *Evidence of Coverage (EOC)*.

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Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area..503-813-2000. All other areas..1-800-813-2000. TTY..711. Language Interpretation Services, all areas..1-800-324-8010

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All plans offered and underwritten by Kaiser Foundation Health Plan
of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

Clackamas County 1183 – Peace Officers
Oregon Traditional Copayment Plan C15B
January 1, 2015 through December 31, 2015

Out-of-Pocket Maximum (Copayment, and Coinsurance amounts count toward the maximum, unless otherwise noted.)	
For one Member	$600 per Calendar Year
For an entire Family	$1,200 per Calendar Year
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	$10
Specialty Care	$10
Urgent Care	$10
Tests (outpatient)	
Preventive tests	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Medications	
Prescription drugs (outpatient)	$10 generic/$20 brand. $0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments.
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$0
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
Inpatient Hospital Services	$0
Hospital Services	
Ambulance Services (per transport)	$75
Emergency department visit	$75 (Waived if admitted)
Inpatient Hospital Services	$0
Outpatient Services (other)	
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Durable medical equipment, external prosthetic devices, and orthotic devices	$0
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$10
Alternative Care	
Alternative care (physician-referred)(limited to 12 visits per Calendar Year)	$10
Alternative care (self-referred)	$10 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.

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Vision Services	
Routine eye exam	$10
Vision hardware and optical Services (ages 18 years and younger)	No charge for one pair standard frames and lenses or 6-month supply contact lenses every 24 months.
Vision hardware and optical Services (ages 19 years and older)	Balance after $200 allowance every 24 months
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	
Outpatient Services	$10
Inpatient hospital & residential Services	$0
Mental Health Services	
Outpatient Services	$10
Inpatient hospital & residential Services	$0
Hearing Aids	
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	$0
Hearing aids (ages 19 years and older)	Not covered
Student Out-of-Area Coverage	
Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year; amounts do not count toward the maximum)	20% of the actual fee the provider, facility, or vendor charged for the Service

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Summary of medical benefits

Clackamas County 1183 – General County Early Retirees
Oregon Deductible Plan 3C15
January 1, 2015 through December 31, 2015

Deductible	
For one Member	$1,000 per Calendar Year
For an entire Family	$3,000 per Calendar Year
Out-of-Pocket Maximum (All Copayment and Coinsurance amounts count toward the maximum, unless otherwise noted.)	
For one Member	$3,000 per Calendar Year
For an entire Family	$9,000 per Calendar Year
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	$25
Specialty Care	20% Coinsurance after Deductible
Urgent Care	$25
Tests (outpatient)	
Preventative Tests	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0
Medications	
Prescription drugs (outpatient)	$15 generic/$30 brand. $0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments.
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$5
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	20% Coinsurance after Deductible
Alternative Care	
Alternative care (physician-referred (limited to 12 visits per Calendar Year))	20% Coinsurance after Deductible
Alternative care (self-referred)	$10 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Vision Services	

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Routine eye exam	$25
Vision hardware and optical Services (ages 18 years and younger)	No charge for one pair standard frames and lenses or 6-month supply contact lenses every 24 months.
Vision hardware and optical Services (ages 19 years and older)	Balance after $200 allowance every 24 months
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Chemical Dependency Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Hearing Aids	
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance after Deductible
Hearing aids (ages 19 years and older)	Balance after $1,500 allowance is applied for each hearing aid per ear every three years
Student Out-of-Area Coverage	
Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year; amounts do not count toward the maximum)	20% of the actual fee the provider, facility, or vendor charged for the Service

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Summary of medical benefits

Clackamas County 1183 – Peace Officers Early Retirees
Oregon Deductible Plan 3C15
January 1, 2015 through December 31, 2015

Deductible	
For one Member	$1,000 per Calendar Year
For an entire Family	$3,000 per Calendar Year
Out-of-Pocket Maximum (All Copayment and Coinsurance amounts count toward the maximum, unless otherwise noted.)	
For one Member	$3,000 per Calendar Year
For an entire Family	$9,000 per Calendar Year
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	$25
Specialty Care	20% Coinsurance after Deductible
Urgent Care	$25
Tests (outpatient)	
Preventative Tests	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0
Medications	
Prescription drugs (outpatient)	$15 generic/$30 brand. $0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments.
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$5
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	20% Coinsurance after Deductible
Alternative Care	
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Vision Services	
Routine eye exam	$25
Vision hardware and optical Services (ages 18 years and younger)	No charge for one pair standard frames and lenses or 6-month supply contact lenses every 24 months.
Vision hardware and optical Services (ages 19 years and older)	Balance after $200 allowance every 24 months
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Chemical Dependency Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Hearing Aids	
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance after Deductible
Hearing aids (ages 19 years and older)	Not covered
Student Out-of-Area Coverage	
Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year; *amounts do not count toward the maximum*)	20% of the actual fee the provider, facility, or vendor charged for the Service

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Summary of dental benefits

Clackamas County 1183
Oregon Dental Plan C
January 1, 2015 through December 31, 2015

Benefit Maximum	None per Calendar Year
	You Pay
Dental Office Visit Charge – Applies to all visits	$5
Deductible (Per Calendar Year; applies to all services unless otherwise indicated)	
For one Member	$0
For an entire Family	$0
Preventive and Diagnostic Services (oral exam, x-rays, teeth cleaning, fluoride) (Not subject to or counted toward the Deductible)	No additional charge
Basic Restoration Services (routine fillings, plastic and steel crowns, simple extractions)	No additional charge
Oral Surgery Services (surgical tooth extractions)	No additional charge
Periodontics (treatment of gum disease, *scaling and root planing*)	No additional charge
Endodontics (root canal therapy)	No additional charge
Major Restoration Services (gold or porcelain crowns, bridges)	$45 for each
Removable Prosthetic Services	
Full and partial dentures	$95 for each partial denture, $65 for each full denture
Relines	$25
Rebases	$25
Emergency Dental Care	
From Participating Providers	Copayments or Coinsurance that normally apply for non-emergency dental care Services.
From Non-Participating Providers outside the Service Area	All Charges over $100
Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)	
Adults and children age 13 years and older	$15
Children age 12 years and younger	$0
Orthodontics	All Members: 50% of Charges up to the $2,000 Lifetime Benefit Maximum, and 100% of Charges thereafter.

Exclusions

- Dental conditions for which Service or reimbursement is required by law to be provided at or by a government agency.
- Cosmetic Services.
- Dental implants unless coverage for dental implants as an additional benefit has been purchased.
- Experimental or investigational treatments.
- Fees a provider may charge for an Emergency Dental Care or Urgent Dental Care visit.
- Full mouth reconstruction and occlusal rehabilitation.
- Genetic testing.

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- Hospital call fees.
- Medical or Hospital Services, unless otherwise specified in this *Summary.*
- Missed appointment fees.
- Orthodontic Services unless orthodontic coverage as an additional benefit has been purchased.
- Drugs obtainable with or without a prescription.
- Prosthetic devices following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns.
- Services covered by workers' compensation or that are the employer's responsibility.
- Services furnished by a family member.
- Services provided or arranged by criminal justice institutions for Members confined therein, unless care would be covered as Emergency Dental Care.
- Speech aid prosthetic devices and follow up modifications.
- Surgery to correct malocclusion or temporomandibular joint disorders.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.

Limitations

- Repair or replacement due to normal wear of fixed and removable prosthetic devices that are less than five years old is not covered.
- Sedation and general anesthesia are not covered, except nitrous oxide.
- Works-in-Progress started prior to effective date of coverage.

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org/dental/nw**
Portland area..503-813-2000. All other areas..1-800-813-2000. TTY..711.
Language Interpretation Services, all areas..1-800-324-8010

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EXHIBIT G

Moda 2015 Contract Changes

moda HEALTH

Clackamas County 10000174
Dental Plan Changes
Effective January 1, 2015

The following is a summary of the significant changes that will be made to the ODS ASO agreement and member handbook effective January 1, 2015. 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, are not included in this summary.

Please answer the following question (this will determine if your Plan is standalone or integrated, according to HIPPA regulations):

1. Are subscribers able to opt out of the dental plan?
   Yes ☐ No ☐

If yes, your Plan is standalone and the maximum annual limit shall apply to all members.
If no, your Plan is integrated with medical, maximum annual limit shall apply to members age 19 and older. Also, the Plan must comply with other ACA requirements, special enrollment, rescission, coverage for adult children up to age 26, waiting period of no more than 90 days, additional rights in internal and external review and SBC.

REGULATORY CHANGES		
Reference	**Change/Rationale/Exceptions**	**Former Benefit**
Coordination of Benefits	Coordinated benefits with individual plans.	Individual plans were not coordinated with.

OTHER BENEFIT CHANGES					
Accepted		**Reference**	**Change/Rationale/Exceptions**	**Former Benefit**	**Claims Impact***
Yes	**No**				
☐	☐	**Benefits and Limitations** – Space Maintainers	Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, or missing permanent teeth are not covered.	No limit on space maintainers	negligible

ADMINISTRATIVE CHANGES	
Reference	**Change/Rationale/Exceptions**
Definitions	Replaced the definition of Benefits with a definition of Covered Service.

Definition	Revised definition of Unregistered Domestic Partner by deleting the criteria list and added criteria that meets the criteria in the Plan's affidavit of domestic partnership.
Definition	Revised Maximum Plan Allowance to change fee schedule for non-participating providers.
Benefits and Limitations	Added stainless steel crowns with a frequency of 24 months by the same dentist to Class II Services. Clarification of current benefit.
Benefits and Limitations	Implant cleaning is limited to once every 3 years. Clarification of current benefit.
Exclusions	Added Duplication and Interpretation of X-rays to exclusions. Clarification of current benefit.
Exclusions	Added Service Related Conditions to exclusions. Treatment of any condition caused by or arising out of a member's service in the armed forces of any country or as a military contractor or from an insurrection or war. Clarification.
Exclusions	Deleted Medicare reference from Services Otherwise Available as Medicare does not cover dental services.
Exclusions	Deleted Services Provided by a Relative from exclusions.
Eligibility Dependents	Added more details as to what is required for a dependent to be determined disabled and to stay on the plan beyond age 26.
Eligibility Qualified Medical Child Support Order (QMCS)	Revised Qualified Medical Child Support Order (QMCS) section. Simplification.
Enrollment Special Enrollment	Moved applicability language. Clarification
Exclusions **Claims Administration & Payment** Third Party Liability	Revised Third Party Liability language. Simplify and clarify
Coordination of Benefits	Moved some sections to Miscellaneous Provisions. No longer part of Coordination of Benefits rules. Applicable to whole plan.
Miscellaneous Provisions	Deleted Request for Information. Redundant to Right to Collect and Release Information.

PREVIOUS CHANGES THAT WERE NOT TAKEN IN THE PAST – DOES THE GROUP WANT TO TAKE NOW?

Accepted		Reference	Change/Rationale/Exceptions	Former Benefit	Claims Impact*
Yes	No				
☐	☐	Benefits and *Limitations* Preventive	Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Evidence based dentistry.	Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars.	-0.23%

☐	☐	Benefits and Limitations Restorative Limitations and Prosthodontic Limitations	Cast restorations and prosthodontics (e.g. bridges, dentures, partials, including alternate benefits) are covered every 7 years. Improvements in industry materials. Crown over an implant is covered once per lifetime. With an implant there is no possibility of recurrent decay, fracture, need for endodontic therapy.	Cast restorations and prosthodontics (e.g. bridges, dentures, partials, including alternate benefits) are covered once every 5 years Crown over an implant is covered once every 5 years	-0.20%
☐	☐	Benefits and Limitations – Diagnostic	Cover complete series x-ray or a panoramic film once every 5 years as part of evidence-based dental dentistry.	Covered every 3 years.	-.11%
☐	☐	Benefits and Limitations – Diagnostic	Cover supplementary bitewing x-rays once every 12 months as part of evidence-based dental dentistry.	Covered twice in a calendar year.	-.20%
☐	☐	Benefits and Limitations – (for groups that don't cover mouthguards)	Cover athletic mouthguards under major services once per year for members age 15 and under and once every 2 years age 16 and over.	Not covered.	+0.1%

ASO AGREEMENT

New agreement with better organization of content so it is easier to find information.

- Language has been updated or added for clarity. To name a few examples:
  - ERISA language has been expanded to clearly define the relationship of each party and the fiduciary responsibilities.
  - The conditions for plan benefit changes have been outlined.
  - There is a more detailed description of the renewal process and the conditions (with timeframes) under which the agreement may be terminated.
  - Legal terms that were not fully addressed in the old agreement have been added.
- There is a new Business Associate Agreement that is compliant with HIPAA/HITECH changes.
- There is a new Exhibit A. Fee Schedule that lists all items that may have a cost to the client (rather than having them scattered throughout the agreement).

*Based on ODS 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. ODS will provide written notice of any additional changes including any modification to premium rates or administrative fees, and will administer such changes accordingly.

EXHIBIT H

Moda Benefit Summaries

moda HEALTH DELTA DENTAL ODS

Dental Benefits Summary
Clackamas County
General County Incentive Dental Plan
Effective January 1, 2015

How To Use this Dental Plan

When you visit your dental provider, tell him or her you are a member of an ODS dental program.

Calendar year maximum, per member	$2,000
Calendar year deductible, per member	$0
Service	**Benefit Amount**
PREVENTIVE - Examination/X-rays (routine exam & bitewing x-rays twice per calendar year) - Prophylaxis (cleanings twice per calendar year) - Fissure Sealants - Fluoride - Space Maintainers	*1st year- 70% 2nd year- 80% 3rd year- 90% 4th year- 100%
BASIC - Restorative Fillings - Oral Surgery (extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Crowns - Cast Restorations	*1st year- 70% 2nd year- 80% 3rd year- 90% 4th year- 100%
MAJOR - Implants - Cast Restorations - Denture and Bridge Work (construction or repair of fixed bridges, partials, and complete dentures)	50%
ORTHODONTICS	**50%

* Under this plan, payments increase by 10% each calendar year provided the individual has visited the dentist at least once during the year. Failure to do so will cause a 10% decrease in payment the following year, although payment will never fall below 70%.

** See your member handbook for specific orthodontic benefits.

Advantages

- **Freedom to choose your dentist** ODS is unique in that we have contracts with over 2,000 licensed dentists in Oregon. As the Delta Dental Plan of Oregon, we offer access to over 142,000 dental professionals nationwide.
- **Professional Arrangements** ODS has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS and our Delta Dental affiliates. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
- **myModa is** a customized member website with current, accurate and easy to understand information about the member's plan. Log onto www.modahealth.com/members to access myModa.

Dependent Eligibility

Dependents are lawful spouse and registered domestic partners under any legal registry in the United States. An unregistered domestic partner is eligible for coverage if he or she complies with the Affidavit of Domestic Partnership provided by the Group. Children are eligible to age 26. This includes adminstrative orders that require the employee to provide health insurance.

This is a benefit summary only.
For a more detailed description of benefits, refer to your member handbook.

Visit our website at www.modahealth.com

Oregon Dental Service (ODS) provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class I Services)

- **Diagnostic** Routine examination and bitewing x-rays limited to twice per calendar year. Full mouth x-rays limited to once every (3) years.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to twice in a calendar year. Topical application of fluoride is covered twice in a calendar year for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a history of periodontal disease or high risk of decay. Sealant benefits are limited to the occlusal surfaces of unrestored permanent Bicuspids and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period

Basic (Class II Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splitting, including crowns or bridgework for splinting are not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate or plastic, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate or plastic. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

Major (Class III Services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Prosthodontic** Replacement of an existing prosthetic device is covered only if it cannot be made satisfactory. Replacement is never covered if existing device is less than 5 years old. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

Visit our website at www.modahealth.com

Oregon Dental Service (ODS) provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

moda HEALTH DELTA DENTAL ODS

Dental Benefits Summary
Clackamas County
POA Incentive Dental Plan
Effective January 1, 2015

How To Use this Dental Plan

When you visit your dental provider, tell him or her you are a member of an ODS dental program.

Calendar year maximum, per member	**$1,500**
Calendar year deductible, per member	**$0**
Service	**Benefit Amount**
PREVENTIVE - Examination/X-rays (routine exam & bitewing x-rays twice per calendar year) - Prophylaxis (cleanings twice per calendar year) - Fissure Sealants - Fluoride - Space Maintainers	***1st year- 70%** **2nd year- 80%** **3rd year- 90%** **4th year- 100%**
BASIC - Restorative Fillings - Oral Surgery (extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Crowns - Cast Restorations	***1st year- 70%** **2nd year- 80%** **3rd year- 90%** **4th year- 100%**
MAJOR - Implants - Cast Restorations - Denture and Bridge Work (construction or repair of fixed bridges, partials, and complete dentures)	**50%**
ORTHODONTICS	****50%**

* Under this plan, payments increase by 10% each calendar year provided the individual has visited the dentist at least once during the year. Failure to do so will cause a 10% decrease in payment the following year, although payment will never fall below 70%.

** See your member handbook for specific orthodontic benefits.

Advantages

- **Freedom to choose your dentist** ODS is unique in that we have contracts with over 2,000 licensed dentists in Oregon. As the Delta Dental Plan of Oregon, we offer access to over 142,000 dental professionals nationwide.
- **Professional Arrangements** ODS has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS and our Delta Dental affiliates. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
- ***myModa is a customized*** member website with current, accurate and easy to understand information about the member's plan. Log onto www.modahealth.com/members to access myModa.

Dependent Eligibility

Dependents are lawful spouse and registered domestic partners under any legal registry in the United States. An unregistered domestic partner is eligible for coverage if he or she complies with the Affidavit of Domestic Partnership provided by the Group. Children are eligible to age 26. This includes adminstrative orders that require the employee to provide health insurance.

This is a benefit summary only.
For a more detailed description of benefits, refer to your member handbook.
Visit our website at www.modahealth.com

Oregon Dental Service (ODS) provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class I Services)

- **Diagnostic** Routine examination limited to twice per calendar year. Bitewing x-rays limited to once every 12 months. Full mouth x-rays limited to once every five (5) years.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to twice in a calendar year. Topical application of fluoride is covered twice in a calendar year for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a history of periodontal disease or high risk of decay. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period

Basic (Class II Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splitting, including crowns or bridgework for splinting are not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate or plastic, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate or plastic. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

Major (Class III Services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Prosthodontic** Replacement of an existing prosthetic device will be covered only if it is unserviceable and cannot be made serviceable, and a replacement of an existing prosthetic device will be covered once in a seven (7) year period. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

Visit our website at www.modahealth.com

moda HEALTH | DELTA DENTAL | ODS

Dental Benefits Summary
Clackamas County
Preventive Dental Plan
Effective January 1, 2015

How To Use this Dental Plan

When you visit your dental provider, tell him or her you are a member of an ODS dental program.

Calendar year maximum, per member	**$2,000**
Calendar year deductible, per member	**$50**
Calendar year maximum deductible, per family	**$100**
Service	**Benefit Amount**
PREVENTIVE* - Examination/X-rays (routine exam & bitewing x-rays twice in a calendar year) - Prophylaxis (cleanings-twice in a calendar year) - Fissure Sealants - Fluoride - Space Maintainers	**100%**
BASIC - Restorative Dentistry (treatment of tooth decay with amalgam, synthetic porcelain & plastic materials - Oral Surgery (extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Partial Cast Restorations	**80%**
MAJOR - Crowns - Implants - Denture and Bridge Work (construction or repair of fixed bridges, partials, and complete dentures)	**70%**
ORTHODONTIC - Eligible employees and their covered dependents	**50% to a $3,000 lifetime maximum**

* **Deductible waived for preventive services.**

Advantages

- **Freedom to choose your dentist** As the Delta Dental Plan, members have the option of choosing a Delta Dental Plan that provides access to over 142,000 dental professionals nationwide. ODS is unique in that we have contracts with over 2,000 licensed dentists in Oregon.
- **Professional Arrangements** ODS has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS and our Delta Dental affiliates. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
- **myModa is** a customized member website with current, accurate and easy to understand information about the member's plan. Log onto www.modahealth.com/members to access myModa.

Dependent Eligibility

Dependents are lawful spouse and registered domestic partners under any legal registry in the United States. An unregistered domestic partner is eligible for coverage if he or she complies with the Affidavit of Domestic Partnership provided by the Group. Children are eligible to age 26. This includes adminstrative orders that require the employee to provide health insurance.

This is a benefit summary only.
For a more detailed description of benefits, refer to your member handbook.

Visit our website at www.modahealth.com

Oregon Dental Service (ODS) provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive

- **Diagnostic** Routine examination and bitewing x-rays limited to twice in a calendar year. Full mouth x-rays limited to once every (3) years.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to twice in a calendar year. Topical application of fluoride is covered twice in a calendar year for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a history of periodontal disease or high risk of decay. Sealant benefits are limited to the occlusal surfaces of unrestored permanent Bicuspids and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.

Basic

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splinting, including crowns or bridgework for splinting, is not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate, plastic or composite, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate, plastic or composite. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

Major

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Restorative** Replacement of necessary crowns, jackets, and gold or full cast restorations is covered only if 5 years have elapsed since last prior crown, jacket, and gold or cast restoration was furnished on the tooth.
- **Prosthodontic** Replacement of an existing prosthetic device is covered only if it cannot be made satisfactory. Replacement is never covered if existing device is less than 5 years old. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygience or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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moda HEALTH | DELTA DENTAL | ODS

Dental Benefits Summary
Clackamas County
Constant Dental Plan
Effective January 1, 2015

How To Use this Dental Plan

When you visit your dental provider, tell him or her you are a member of an ODS dental program.

Calendar year maximum, per member	$2,000
Calendar year deductible, per member	**$0**
Service	**Benefit Amount**
PREVENTIVE - Examination/X-rays (routine exam & bitewing x-rays twice per calendar year) - Prophylaxis (cleanings twice per calendar year) - Fissure Sealants - Fluoride - Space Maintainers	50%
BASIC - Restorative Fillings - Oral Surgery (extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Crowns - Cast Restorations	50%
MAJOR - Implants - Cast Restorations - Denture and Bridge Work (construction or repair of fixed bridges, partials, and complete dentures)	50%

Advantages

- **Freedom to choose your dentist** ODS is unique in that we have contracts with over 2,000 licensed dentists in Oregon. As the Delta Dental Plan of Oregon, we offer access to over 142,000 dental professionals nationwide.
- **Professional Arrangements** ODS has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS and our Delta Dental affiliates. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
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LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class I Services)

- **Diagnostic** Routine examination and bitewing x-rays limited to twice per calendar year. Full mouth x-rays limited to once every (3) years.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to twice in a calendar year. Topical application of fluoride is covered twice in a calendar year for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a history of periodontal disease or high risk of decay. Sealant benefits are limited to the occlusal surfaces of unrestored permanent Bicuspids and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.

Basic (Class II Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splitting, including crowns or bridgework for splinting are not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate or plastic, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate or plastic. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

Major (Class III Services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Prosthodontic** Replacement of an existing prosthetic device is covered only if it cannot be made satisfactory. Replacement is never covered if existing device is less than 5 years old. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Orthodontic services.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

Visit our website at www.modahealth.com

Oregon Dental Service (ODS) provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

EXHIBIT I

Self-funded Dental Plan Underwriting Calculation

Clackamas County

2015 Preliminary Projection - Dental

	Self-Funded Dental				
Most Recent 12 Months Ending	***Incentive GC***	***Incentive POA***	***Constant (50%)*** ***June 30, 2014***	***Preventive***	***Combined***
Mature Months	12	12	12	12	12
Paid Claims for Entire 12-Month Period	$1,112,057	$482,263	$40,544	$439,242	$2,074,106
Stop loss/Pooling Credit	0	0	0	0	0
Historical Benefit Changes Adjustment	1.067	1.001	1.049	1.001	1.029
Adjusted Net Paid Claims during this Period	$1,186,258	$482,811	$42,526	$439,686	$2,151,281
Average Enrollment Setback (1) Month	742	327	74	287	1,430
Adjusted Paid Claims per Capita per Month (PEPM)	$133.23	$123.04	$47.89	$127.67	$125.37
Annual Trend	6.0%	6.0%	6.0%	6.0%	6.0%
Number of Months of Trend	19	19	19	19	19
Extended Trend Factor	1.097	1.097	1.097	1.097	1.097
Multiplicative Adjustments Not Related to Trend	1.000	1.000	1.000	1.000	1.000
Projected Claims PEPM	**$146.10**	**$134.93**	**$52.52**	**$140.01**	**$120.87**
Claims Fluctuation Margin	0.0%	0.0%	0.0%	0.0%	0.0%
Projected Claims PEPM with Margin	**$146.10**	**$134.93**	**$52.52**	**$140.01**	**$120.87**
2015 Moda Administration Fee	$6.10	$6.10	$6.10	$6.10	$6.10
Projected Total Cost (Claims+Margin+Admin) PEPM	**$152.20**	**$141.03**	**$58.62**	**$146.11**	**$126.97**
Current 2014 Budget, based on Current Rates	$156.71	$149.65	$71.13	$132.66	$128.97
Needed Increase to 2014 Rates	**-2.9%**	**-5.8%**	**-17.6%**	**10.1%**	**-1.6%**

EXHIBIT J

VSP Benefit Summaries

VSP®
Vision care for life

Get the best in eyecare and eyewear with CLACKAMAS COUNTY (General County) and VSP® Vision Care.

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness over profit.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP doctor including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, retail chain affiliate, or any other provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.**
  To find a VSP doctor or retail chain affiliate, visit **vsp.com** or call **800.877.7195.**
- **Review your benefit information.** Once your benefit is effective, visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.**
  There's no ID card necessary.

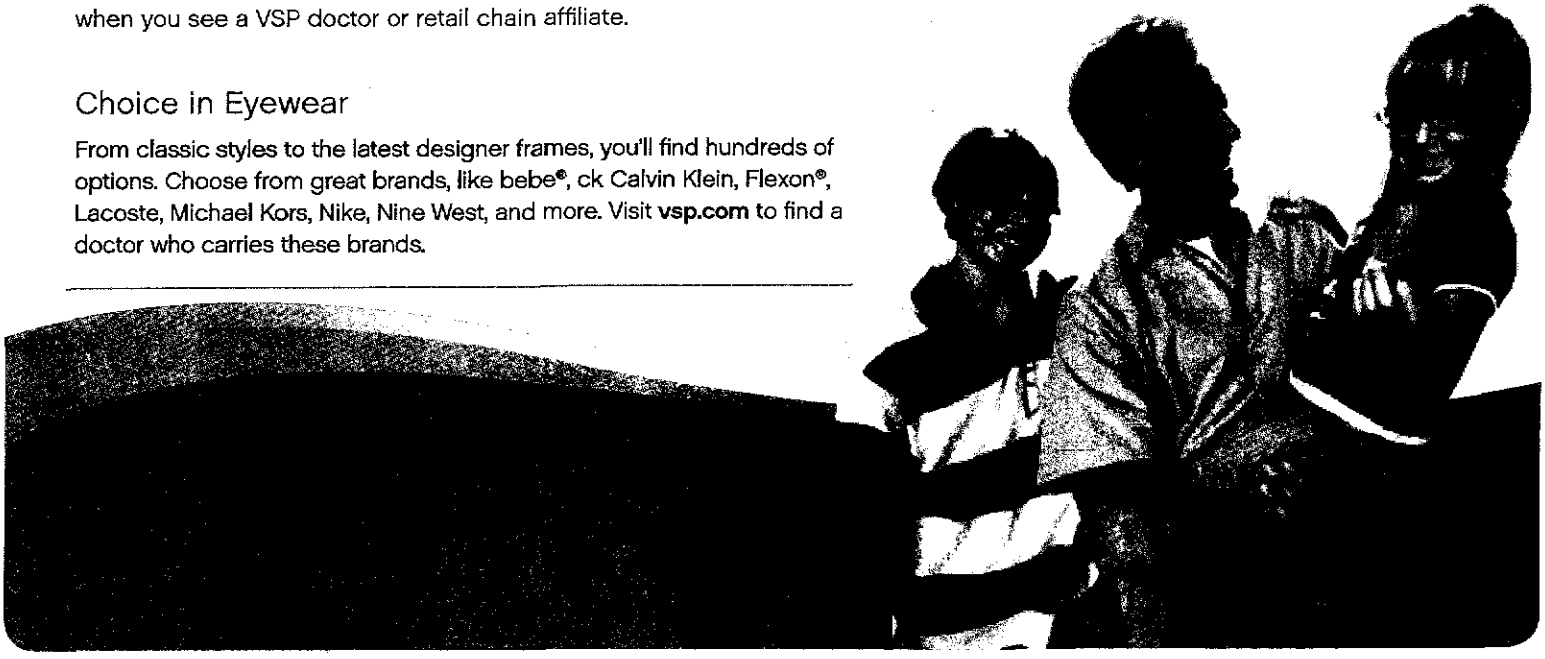
That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor or retail chain affiliate.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from great brands, like bebe®, ck Calvin Klein, Flexon®, Lacoste, Michael Kors, Nike, Nine West, and more. Visit **vsp.com** to find a doctor who carries these brands.

See why we're consumers' #1 choice in vision care.

Contact us.
vsp.com | 800.877.7195



Your VSP Vision Benefits Summary

CLACKAMAS COUNTY (General County) and VSP provide you and your dependents with an affordable eyecare plan.

VSP Coverage Effective Date: 01/01/2015
VSP Doctor Network: VSP Choice

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
	Your Coverage with VSP Doctors and Affiliate Providers*		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$0	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • $70 allowance for frame at Costco • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$30 $30 $30	Every calendar year
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam.....up to $45	Single Vision Lenses.....up to $30	Lined Trifocal Lenses.....up to $70	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $50	Progressive Lenses.....up to $50	

*Coverage with a retail chain affiliate may be different. Check with your affiliate to confirm they are a participating provider.
Once your benefit is effective, visit vsp.com for details. 50%.
Plan information is subject to change. In the event of a conflict between this information and your employer's contract with VSP, the terms of the contract will prevail. Based on applicable law. Benefits may vary by location.

See why we're consumers' #1 choice in vision care.

Contact us. **vsp.com | 800.877.7195**

VSP®
Vision care for life

Get the best in eyecare and eyewear with CLACKAMAS COUNTY (POA) and VSP® Vision Care.

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Register at vsp.com.**
  Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.**
  To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com.**

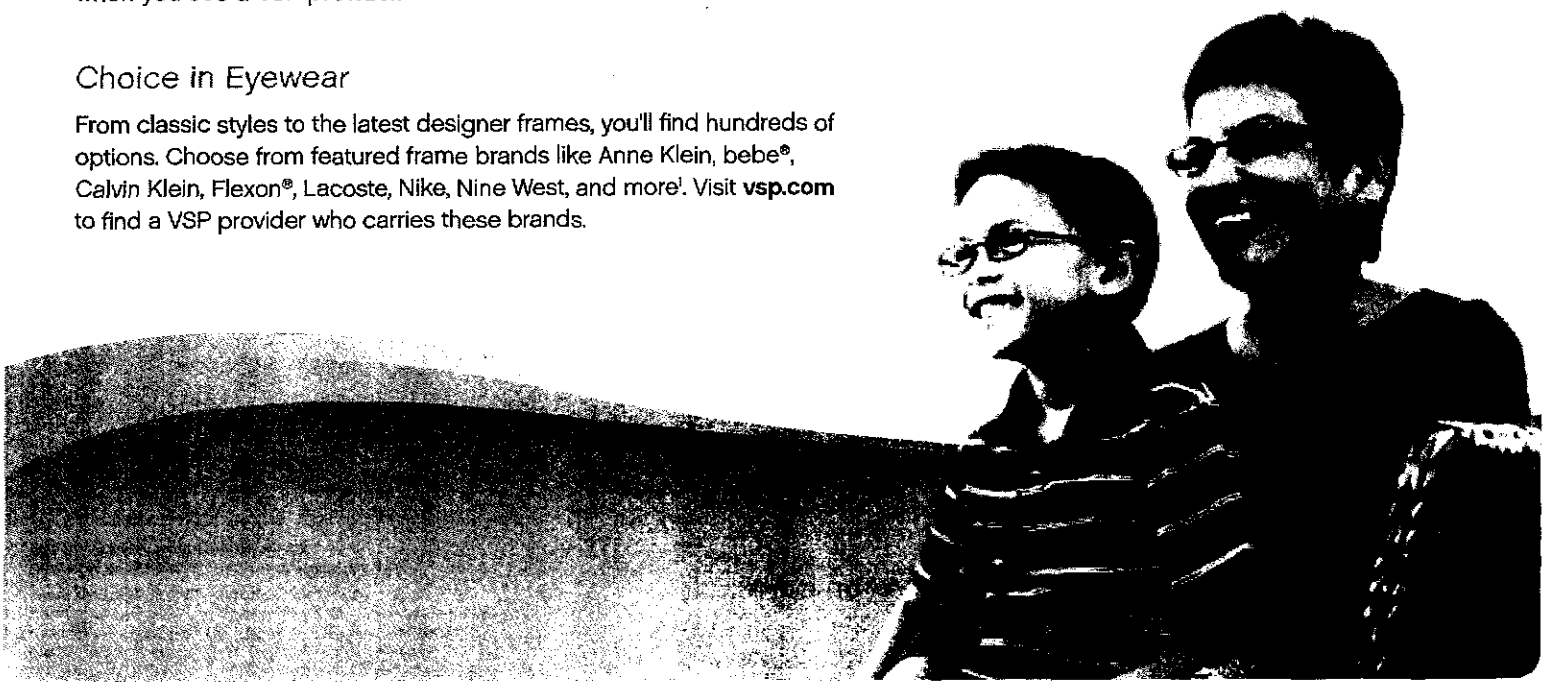
That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

See why we're consumers' #1 choice in vision care[2].

Contact us. **800.877.7195**
vsp.com



Your VSP Vision Benefits Summary

CLACKAMAS COUNTY (POA) and VSP provide you with an affordable eyecare plan. This plan is for adults and children over 19 years old.

VSP Coverage Effective Date: 01/01/2015
VSP Provider Network: VSP Choice

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$0	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 allowance for frame at Costco		Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	$0	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam.....up to $45	Single Vision Lenses.....up to $30	Lined Trifocal Lenses.....up to $65	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $50	Progressive Lenses.....up to $50	

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

See why we're consumers' #1 choice in vision care[2].
Contact us. **800.877.7195**
vsp.com

[1]Brands/Promotion subject to change
[2]IPSOS National Vision Plan Member Research, 2012

VSP
Vision care for life

Clackamas County (POA) partners with VSP® to provide Vision Coverage for Children

Your child is fully covered for an eye exam and glasses or contacts every year.

Your child's eyes deserve the best care to keep them healthy year after year. Plus, with VSP, you'll get a great value on eyecare and eyewear for your child.

You'll like what you see with VSP.

Log in to vsp.com to:

- **Find a VSP doctor who's right for your child.**
- **Review your child's benefit information** and plan coverage before an appointment.
- **At the appointment, tell them your child has VSP.**

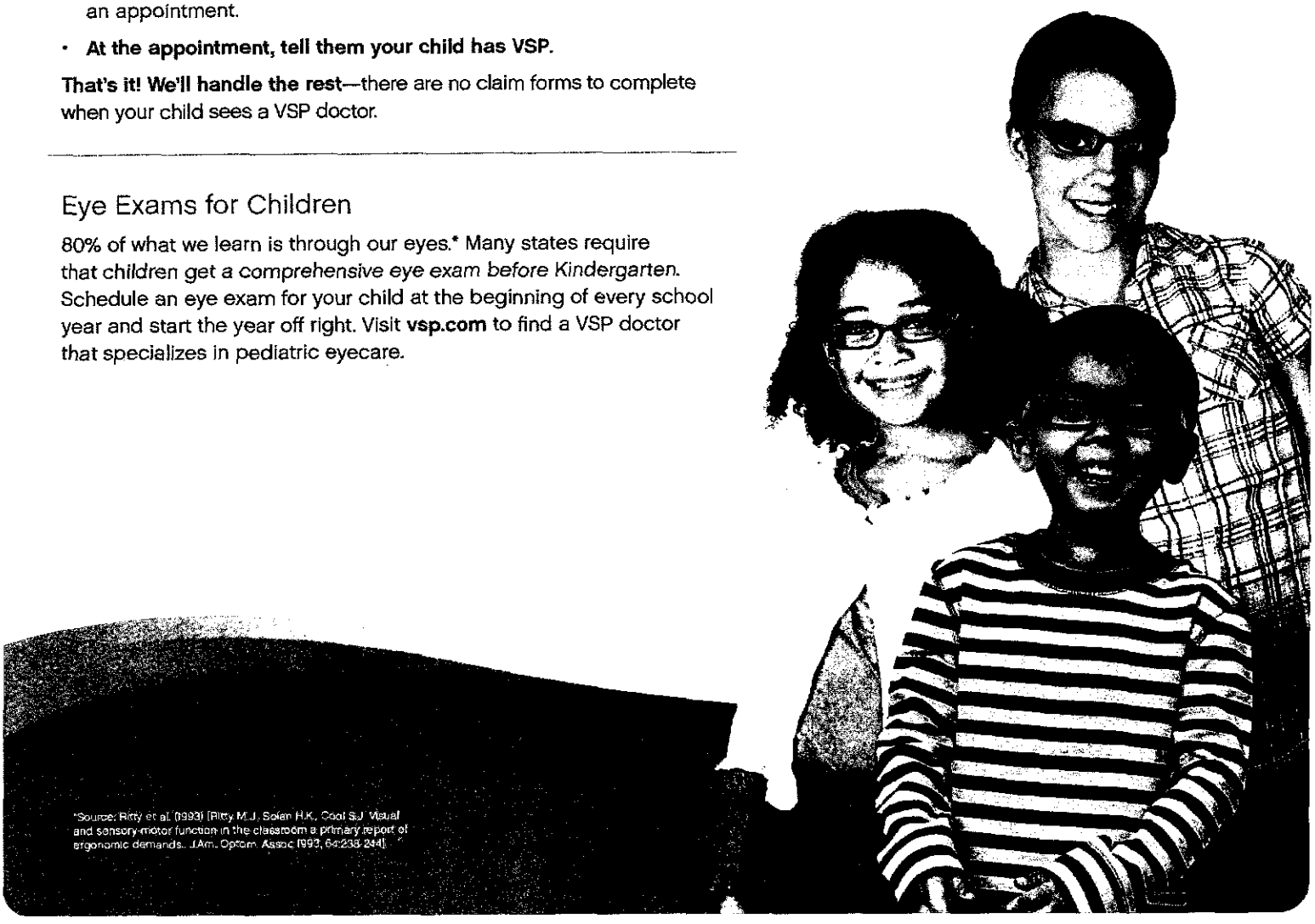
That's it! We'll handle the rest—there are no claim forms to complete when your child sees a VSP doctor.

Eye Exams for Children

80% of what we learn is through our eyes.* Many states require that children get a *comprehensive eye exam before Kindergarten.* Schedule an eye exam for your child at the beginning of every school year and start the year off right. Visit **vsp.com** to find a VSP doctor that specializes in pediatric eyecare.

Visit **vsp.com** for more details on your child's vision benefit and the exclusive savings and promotions for VSP members.

Contact us.
vsp.com | 800-877-7195



*Source: Ritty et al. (1993) [Ritty M.J., Solan H.K., Cool S.J. Visual and sensory-motor function in the classroom: a primary report of ergonomic demands. J.Am. Optom. Assoc (1993, 64:238-244]

Vision Benefit Summary- Coverage for children 19 and under

Taking care of your child's eyes with VSP includes a covered-in-full benefit outlined below. You'll have access to the highest quality vision care from a VSP doctor you can trust. Visit **vsp.com** to find a doctor who's right for your child and one who carries children's frames from our exclusive Otis & Piper™ Eyewear Collection.

POA EMPLOYEES' Children age 0-18

Benefit	Description	Copay (Your cost)	Frequency
	Your Coverage with a VSP Choice Doctor		
WellVision Exam®	• A thorough eye exam that tests for childhood eye health and vision issues, like nearsightedness, amblyopia (lazy eye), and strabismus (cross-eye)	$0	Every 12 months
Prescription Glasses			
Frames	• Frames from our exclusive Otis & Piper Eyewear Collection	$0	Every 12 months
Lenses	• Single vision, lined bifocal, lined trifocal, or lenticular lenses • Polycarbonate, scratch-resistant coating, and UV protection	$0	Every 12 months
Lens Enhancements	• Average savings of 20% - 25% on lens enhancements		Every 12 months

Contacts (Instead of glasses)	• Contact lens exam and a minimum three-month's supply of contact lenses are fully covered.
	  • Standard (one pair annually)
	  • Monthly (six-month supply)
	  • Bi-weekly (three-month supply)
	  • Dailies (three-month supply)
	• Ask your VSP doctor which contacts qualify for your child's plan.
		$0	Every 12 months

Extra Savings	**Glasses and Sunglasses** • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor. You pay 50% of the provider's billed amount.

Once your child's benefit is effective, visit vsp.com for details. VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and the applicable contract, the terms of the contract will prevail.

Clackamas County

Health Care Flexible Spending Account Plan

A Component Plan of the
Clackamas County
Flexible Benefits Program

AMENDED AND RESTATED

Effective January 1, ~~2014~~ 2015

PREAMBLE

THIS HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN (hereinafter referred to as the "Plan" and known as the Clackamas County Health Care Flexible Spending Account Plan) is amended and restated effective January 1, ~~2014~~2015, by Clackamas County (hereinafter "Employer").

WHEREAS, the Employer established this Plan effective July 1, 1985, to allow Employees who become covered under the Plan to elect to receive reimbursement of medical expenses that are excluded from gross income under Section 105(b) of the Internal Revenue Code of 1986, as amended (hereinafter "Code"), as provided herein and in the terms of the Clackamas County Flexible Benefits Program (hereinafter "Program"); and

WHEREAS, this Plan is a Component Plan of the Program and, except to the extent otherwise expressly provided herein, is governed by the terms of that Program; and

WHEREAS, the Employer last amended and restated the Plan effective January 1, 2014 and

WHEREAS, the Employer desires to again amend and restate the Plan to effect certain changes and to reflect changes in applicable law; and

WHEREAS, this Plan is intended to qualify as a self-insured medical expense reimbursement plan within the meaning of Code Section 105(h) and comply with any other applicable provisions of law; and

NOW, THEREFORE, the Employer does hereby amend and restate the Plan as set forth in the following pages, effective January 1, 2015, except as otherwise specifically stated herein.

SECTION 1 — DEFINITIONS

The terms when used herein that are defined in Section 1 of the Program shall have the same meaning as therein defined, and the following additional terms shall have the following meanings unless a different meaning is plainly required by the context. Capitalized terms are used throughout the Plan text for terms defined by this and other sections.

1.1 Dependent

"Dependent" means with respect to any Participant, such Participant's (1) legal spouse, or (2) any child of the Participants who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant who receives over half of his or her support from the Participant (or the Participant and spouse combined) for the tax year in which medical expenses are incurred (or in the case of a divorced or legally separated Participant, the child receives over half his or her support from either or both parents combined) and who meets one of the following descriptions:

(a) child who is physically or mentally incapable of self-support due to a mental or physical disability that arose prior to the child's attaining age twenty-one (21); or

(b) child for whom the Participant or the Participant's spouse is a court appointed guardian.

A child adopted by a Participant shall be regarded as a child of the Participant for all purposes herein. A stepchild of a Participant shall be regarded as a child of the Participant if the Plan Administrator determines, with sole discretion, that such stepchild is in good faith treated by the Participant as a child and such stepchild lives with the Participant or would live with the Participant but for such stepchild's resident attendance at an accredited educational institution.

1.2 Medical Expense

"Medical Expense" means an Eligible Expense for which documentation approved by the Plan Administrator has been provided and that is incurred prior to the date participation in the Plan terminates, by a Participant on behalf of himself or herself, or a Dependent:

(a) that would have been paid directly or reimbursed pursuant to another Employer-sponsored health policy, plan or program, but for the application of a deductible or copayment, dollar or other specific limitation on amount of coverage; or

(b) that is paid for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body, or for transportation for or essential to any of the foregoing, as these terms are used in Code Section 213(d) and amplified or explained by regulations and rulings promulgated under Code Section 213.

Notwithstanding the foregoing, a "Medical Expense" shall not include premium payments for long-term care coverage, expense payments for long-term care services, premium payments for other health care coverage, or expenses that have been reimbursed or are reimbursable under any other health care coverage. A Medical Expense is incurred at the time that the service giving rise to the expense is performed.

1.3 Plan

"Plan" means the Clackamas County Health Care Flexible Spending Account Plan as amended from time to time.

1.4 Program

"Program" means the Clackamas County Flexible Benefits Program as amended from time to time.

SECTION 2 — BENEFITS

2.1 Reimbursement Options

Subject to the conditions and limitations set forth in the Plan and the Program, each Participant who elects to participate in the Plan may designate any amount from a minimum of $5 per pay period to a maximum of $2500 during the Plan Year for reimbursement of Medical Expenses.

2.2 Election of Reimbursement

A Participant elects to participate in this Plan by submitting an Annual Electronic Enrollment to the Plan Administrator as provided in Section 4.2 of the Program and may claim reimbursement by submitting a Request for Reimbursement to the Plan Administrator. A Participant may submit a Request for Reimbursement at any time and at the end of the Plan Year regardless of the claim amount. In the event that a Participant does not qualify for reimbursement of the amount elected during the Plan Year, the difference greater than $500 between the amount elected and actual reimbursement shall be forfeited. The unreimbursed amount up to $500 may be carried over to the following plan year.

In the event of a Participant's death, the surviving spouse or the administrator or executor of a deceased Participant's estate may claim reimbursement of Medical Expenses incurred, provided that the claim is submitted within ninety (90) days after the end of the Plan Year ~~(or ninety (90) days following the end of the Grace Period~~.

2.3 Payment of Reimbursements

The Plan Administrator shall reimburse Medical Expenses that are properly documented to the extent that the Medical Expenses do not exceed the total annual amount of reimbursement elected by the Participant, plus any carryover.

Notwithstanding Section 4.5 of the Program, a Medical Expense may be reimbursed at any time during the Coverage Period even if the portion of the Participant's account balance that is designated for such option at the time of reimbursement is less than the requested reimbursement; provided, however, that the total Plan reimbursements for the Coverage Period shall not exceed the total amount of Plan coverage elected by the Participant for such Coverage Period, plus any carryover.

The Plan Administrator shall reimburse a Participant who is entitled to a reimbursement as soon as practical after processing the Participant's Request for Reimbursement. No Participant shall have any rights or be entitled to any benefits under the Plan unless a Request for Reimbursement is submitted. The Plan Administrator will review each Request for Reimbursement submitted to determine whether (i) the expenses for which reimbursement is sought are reimbursable Eligible Expenses and (ii) the Request for Reimbursement is accompanied by the required documentation. Each Request for Reimbursement must include the following, and any other information that may be required by the Plan Administrator:

(a) a written statement from an independent third party that the expense has been incurred, the date it was incurred, and the amount of the expense; and

(b) a written statement from the Participant that the expense has not been reimbursed and is not reimbursable under any other health plan.

2.4 Maximum Reimbursements

Reimbursements during a Plan Year shall not exceed the lesser of:

(a) the total annual amount designated on an Annual Enrollment Form for Medical Expenses for such Plan Year plus any carryover; or

(b) the amount of Eligible Expenses for which reimbursement is properly requested.

2.5 Qualified Reservist Distribution (QRD)

A Participant who is a reservist in the armed forces and is called to active duty for a period of at least 180 days or for an indefinite period may request payment of the balance of the Participant's account as taxable wages:

(a) the Participant must submit a Request for QRD to the Plan Administrator;

(b) the QRD will be equal to the amount contributed to the health FSA as of the QRD request, minus the amount of any qualified Requests for Reimbursements received as of the date of the QRD request;

(c) the Participant will not be allowed to submit any additional Requests for Reimbursement after the QRD for the remainder of the Plan year.

SECTION 3 —
CONTINUATION OF COVERAGE

3.1 Continuation of Coverage

Notwithstanding any other Plan provision regarding termination of coverage, in the event that participation would terminate due to one of the following events, a Participant and any covered Dependents may elect to continue coverage on an after-tax, self-pay basis as provided in this section. The terms and conditions of this continuation coverage shall be the minimum necessary to satisfy the requirements of COBRA Continuation Coverage.

With respect to a Participant or covered Dependent, if participation would terminate due to (i) a termination of employment (for reasons other than gross misconduct), (ii) a reduction of hours, or (iii) the end of an FMLA leave of absence (without regard to whether coverage was maintained during the leave), such individual may continue coverage for the remainder of the calendar year in which the qualifying event occurred.

The Clackamas County Health Care Account Plan is amended and restated by Clackamas County effective January 1, 2015.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed on this _____ day of _____, 2014.

FOR CLACKAMAS COUNTY

By the Board of County Commissioners:

_____

Chair

_____

Recording Secretary

Table of Contents

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TALENT · HEALTH · RETIREMENT · INVESTMENTS

HEALTH PLAN FUNDING OPTIONS
SELF-FUNDING PROVIDENCE HEALTH PLAN
CLACKAMAS COUNTY

October 21, 2014

Jan Long, CEBS
Joe Bober

MARSH & McLENNAN COMPANIES

What is Self-Funding?

- Also called self-insurance, it is a type of group health plan funding arrangement under which the plan sponsor (employer) bears most or all of the financial risk of the plan and is responsible for the actual costs of services provided under the plan
- Clackamas County currently self-insures its dental and short term disability programs
- All major aspects of the services related to providing group health coverage are unbundled and include a third-party administrator (TPA) or an insurance company on an administrative services only (ASO) basis to process claims

Why do Employers Self-Fund their Health Plans?

- Organizations generally self-fund to achieve savings over time and to achieve greater control of the plan design
- When an employer increases in the number of employees, historical claims become a more credible predictor of future claims. Thus, the risks involved in self-funding medical benefits reduce as a group grows in size.
- Cost savings can be achieved through the following:
  - Self-funding can improve cash flow because the employer is not required to make conventional premium payments. The employer may delay payment until it is actually needed to pay claims.
  - Insurance company administrative expenses are usually less under self-funding
  - Under self-funding, the employer holds the Incurred But Not Reported (IBNR) reserves and can earn interest on those reserves
  - Elimination of the 2% state premium tax for non-domiciled carriers
  - Elimination of the 1% HealthyOregon premium tax
  - Not required to pay the insurer tax under Health Care Reform
  - Potential to beat the insurance company's fully insured claims "trend"
  - Control over plan design (avoid state legislative requirements- as a practice government groups follow state mandates)

Pros & Cons of Self-Funding

Pros

- Cash flow
- Plan design flexibility
- "Profits" to employer
- Ability to make claim exceptions
- Employer holds reserves
- Expanded availability of data and increased data transparency
- Better ability to manage benefit plan

Cons

- Increased financial risk
- Costs are not as predictable on a monthly basis
- More involvement required by employer's Human Resource and/or Finance Staff
- HIPAA compliance responsibility
- Legal and fiduciary responsibility

Budgeting in a Self-Funded Environment

- In a fully insured arrangement, the insurance company establishes the premium rates and they are generally fixed for one year
  - The role of the employer and/or consultant is to negotiate the best premium rate possible
  - Generally requires less involvement from the consultant, HR, and finance
- Under self-insurance, the employer and/or consultant or carrier develop budgeted rates, also called premium equivalents
  - The process of setting self-funded rates is straightforward, although it will typically require more time and input from the parties involved
  - Components include all fixed costs/administration expenses, expected claims, and margin (optional)
  - The employer is also responsible for setting IBNR reserves for the self-funded plan

Budgeting in a Self-Funded Environment *(cont'd)*

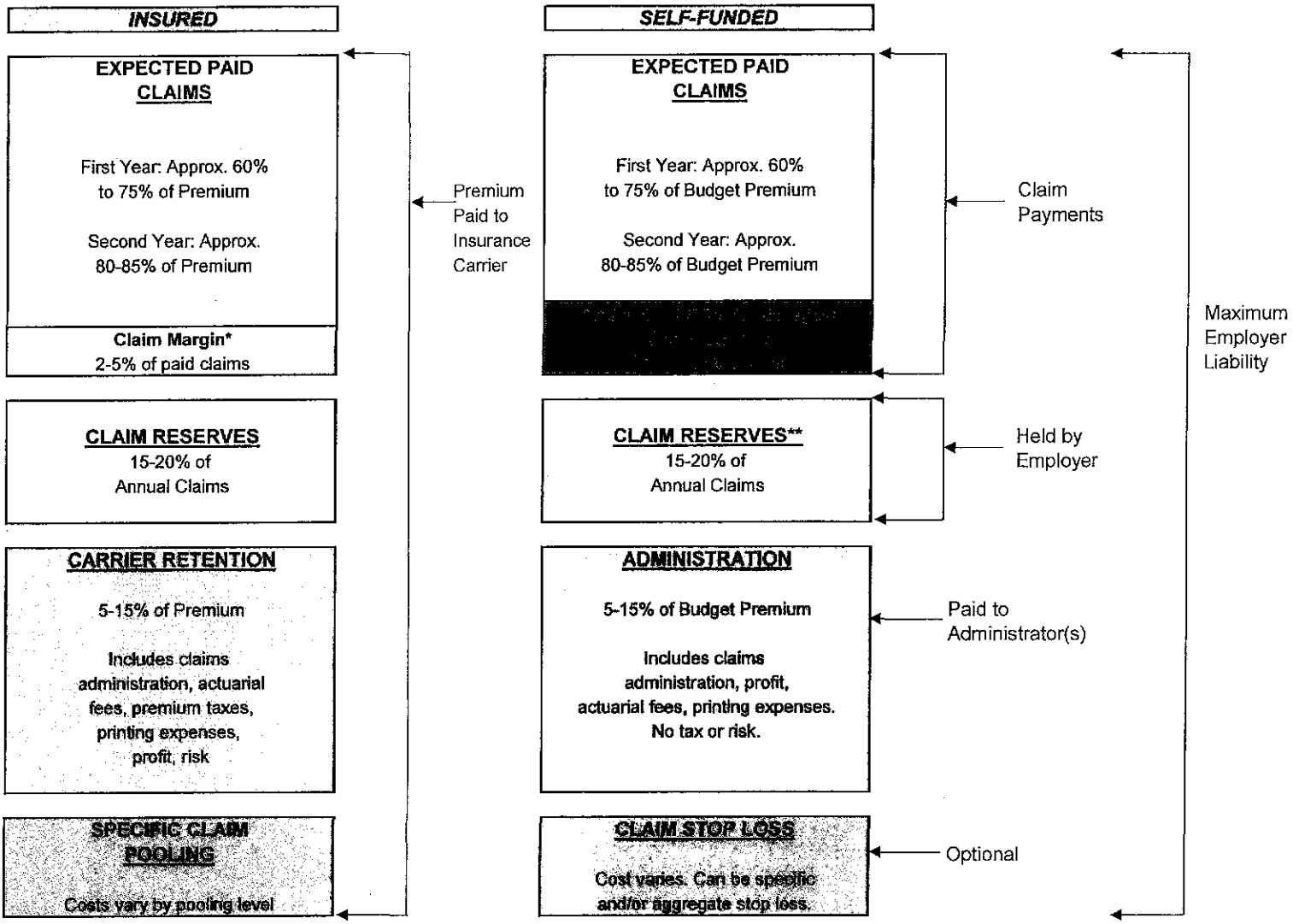
- Why do we calculate premium equivalents?
  - Basis for setting employee contributions
  - Basis for projecting total plan costs/setting budgets
  - Required to set COBRA rates
- While more time is involved from the employer, the increased flexibility in budgeting is an advantage
  - Employer must pay closer attention to ongoing plan experience throughout the year to monitor actual experience against budget
  - Employer's HR and finance departments can determine the acceptable level of conservatism (trend factors, margin component, etc.)

Other Considerations in a Self-Funded Environment

- No change to current carriers required
- No change to current benefits required
- Benefits Review Committee continues for General County Plans
- Plans continue to be underwritten on a combined basis
- Kaiser plans would remain fully insured


MERCER

CONVENTIONAL INSURED FUNDING
VS.
SELF-FUNDING



*May be refunded to Employer under certain funding arrangements

**Interest earnings may help defray plan costs.

Clackamas County

Self-Funded Projection

Effective Date: January 1, 2015 through December 31, 2015

Assumes No Plan Changes for 2015 Except ACA Mandated Changes

Line #	Claims Projection		Med/Rx
	Experience Period		7/13-6/14
1	Contract Months		17,297
2	Member Months		46,424
3	Adjusted Paid Claims		17,267,432
4	Change in Reserve		(382,088)
5	Incurred Claims		16,885,344
6	Trend (Annual)		8.00%
7	Extended Trend (# of months)	18	1.1224
8	Trended Incurred Claims		18,951,585
9	Margin	1.0%	189,516
10	**Estimated Renewal Claims Cost**		**$19,141,101**
	Expenses		
			PEPM
11	Admin. Fee		$36.01
12	PPO Fee		7.55
13	Case Management/Disease Management		8.20
14	Specific Stop Loss @ $150,000 (Optum)*		102.00
15	Aggregate Stop Loss (Optum)*		3.90
16	ACA Fee		9.85
17	Total Cost Per Employee		$167.51
18	**Annual Expenses**		**$2,897,484**
	Estimated Annual Claims Plus Expenses		
19	**Estimated Annual Claims plus Expenses**		**$22,038,585**
20	**Average # of Members**		**3,869**
21	***Projected Self-Funded Per Member Per Month Cost***		**$474.72**
22	**Fully Insured Renewal Per Member Per Month Cost**		**$479.67**

* Optum will need data through September 2014 in order to finalize stop loss rates.

All estimates based upon the information available at a point in time, are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

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