CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS

Study Session Worksheet

Presentation Date: 10/22/13 **Approximate Start Time:** 3:30 pm **Approximate Length:** 30 min.

Presentation Title: Benefits Renewals for 2014

Department: Employee Services

Presenters: Nancy Drury, Director of Employee Services
Carolyn Williams, Benefits Manager

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 2014 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 of updates to the Flexible Benefits Program plan document.

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 2014 employee benefit plan renewals. The County must confirm the renewals prior to November 1, 2013 to ensure coverage for the 2014 plan year. See attached Renewal Report for detailed information on the 2014 renewals.

Medical & Dental
Preliminary renewals for the General County Providence plans were 8.3% for the Personal Option and 6.7% for the Open Option. For the Peace Officers' Providence plans, the increases were 3.0% for the Personal Option and 8.8% for the Open Option.

Providence agreed to recalculate the renewals to include June 2013 claims experience which turned out to be very favorable. The result was a decrease by about 2 percentage points on each plan. Providence further agreed to make a small additional reduction on the General County Personal Option plan to keep the premium below the cap in the collective bargaining agreements.

The increase to the Kaiser Medical plans for both General County and Peace Officers is 8.0%. With this increase, the Kaiser plans are now comparable in cost to the Providence plans but still remain below the cap.

The medical plan renewals include additional fees as a result of the Affordable Care Act, including the Patient Centered Outcome and Research Institute fees, temporary reinsurance fees and health insurance industry fees. These comprise about 2 percentage points of the medical plan renewals.

The self-insured dental plans administered by ODS range will increase by 0-12.3%. The increase is due to a plan change approved by the Benefits Review Committee to raise the annual maximum from $1500 to $2000. The fully-insured Kaiser dental plan will increase by 2.9%.

Other Benefits
The group term life insurance provided through Met Life will decrease by 19.9% for represented employees and decrease by 20.1% for nonrepresented employees. Dependent life will decrease by 9.5% and the employee-paid group universal life will decrease by 20%.

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 16.7% decrease.

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

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.

Flexible Benefits Program Plan Documents
Our flexible benefits program is governed by the Departments of Labor and Treasury. Under the Internal Revenue Code, the program must have a written plan document that defines how the program will function. It is necessary to update our plan documents due to federal action via the Affordable Care Act and the Supreme Court decision on the Defense of Marriage Act. We have changed some administrative practices that also are reflected in the revised plan documents for Clackamas County and the Housing Authority of Clackamas County.

The changes include:

- References to electronic enrollment
- Addition of foster children as dependents
- Definition of dependent and spouse
- Definition of the Affordable Care Act
- Continuation of benefits while on leave of absence
- Creation of a default enrollment option for medical, dental and life insurance
- Addition of a dental opt-out option
- Reference to the grace period for health flexible spending accounts

FINANCIAL IMPLICATIONS (current year and ongoing):
The estimated fiscal impact for the 2014 plan year is:

Medical:	$1,392,677
Dental:	100,389
Life:	(77,747)
STD	(21,358)
Total:	$1,393,960

LEGAL/POLICY REQUIREMENTS:
Employee benefits must be provided as required under the collective bargaining agreements and County policy. The plan documents have been reviewed by an ERISA attorney at Mercer, our benefits consulting firm.

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 as evidenced by Providence's flexibility with renewal increases. The plan documents must be updated or the County will lose the favorable tax treatment of our benefit plans.

RECOMMENDATION:

1. Approve renewal contracts with Kaiser, Providence Health Plan, MODA, Metropolitan Life, Standard Insurance and Flex-Plan.
2. Pay 95% of the premiums for the medical coverage, and 100% of the premiums for dental, life and disability plans for nonrepresented employees.
3. Approve the revisions to the Clackamas County Flexible Benefits Program plan document.

ATTACHMENTS:

Mercer's 2014 Health and Welfare Benefit Plan Renewal Report
Flexible Benefits Program plan document

SUBMITTED BY:

Division Director/Head Approval _____
Department Director/Head Approval _____
County Administrator Approval _____

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

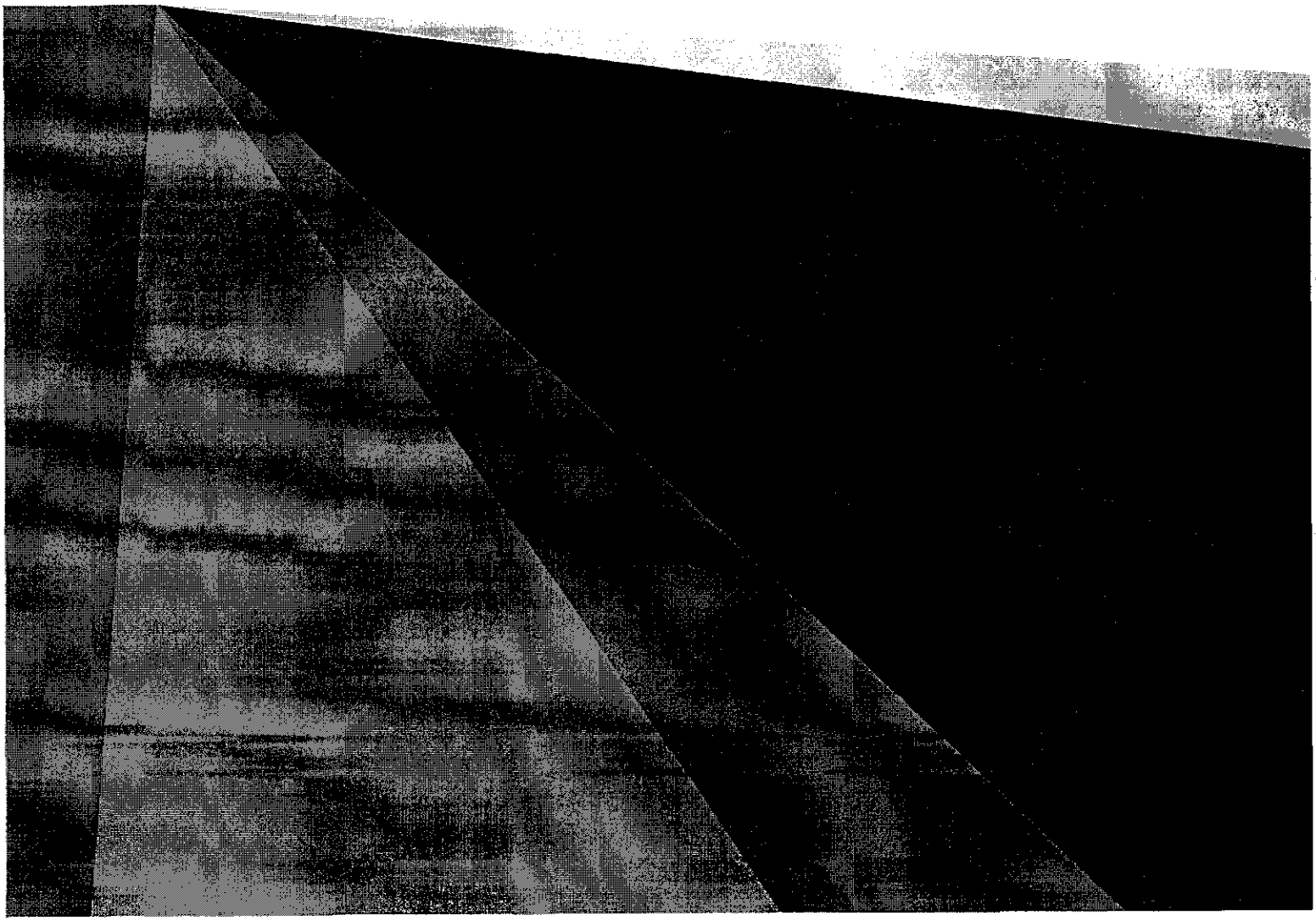
TALENT • HEALTH • RETIREMENT • INVESTMENTS

MERCER

2014 HEALTH AND WELFARE BENEFIT PLAN RENEWAL REPORT

CLACKAMAS COUNTY

OCTOBER 14, 2013



MARSH & McLENNAN COMPANIES

CONTENTS

1

Summary

The Clackamas County General County and Peace Officers Association (POA) 2014 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, only making the legislatively required benefit changes. The BRC elected benefit changes to the Moda dental plans. The accepted plan design changes are described later in this report.

The POA decided to renew all the POA medical/pharmacy and dental plans without changes.

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

	Rates PEPM		
	2013	2014	% Change
Medical/Prescription/Vision Plans			
Providence Health Plan – General County [1]			
Personal Option 20/20/1200 $500 Common Deductible			
Employee Only	$599.87	$629.42	
Employee + Spouse	1,199.82	1,258.92	
Employee + Children	1,079.75	1,132.94	
Employee + Family	1,799.62	1,888.27	
Composite	1,315.21	1,379.99	**4.9%**
Open Option 15/10/30/2000 $500 Common Deductible			
Employee Only	$615.56	$639.96	
Employee + Spouse	1,231.20	1,279.99	
Employee + Children	1,107.99	1,151.91	
Employee + Family	1,846.69	1,919.88	
Composite	1,337.29	1,390.29	**4.0%**
Providence Health Plan – POA [1]			
Personal Option 15/0/1000			
Employee Only	$659.42	$665.80	
Employee + Spouse	1,318.93	1,331.69	
Employee + Children	1,186.95	1,198.42	
Employee + Family	1,978.27	1,997.41	
Composite	1,597.28	1,612.73	**1.0%**
Open Option 10/0/20/2000 $50 Common Deductible			
Employee Only	$653.76	$684.61	
Employee + Spouse	1,307.61	1,369.31	
Employee + Children	1,176.76	1,232.28	
Employee + Family	1,961.29	2,053.84	
Composite	1,591.17	1,666.25	**4.7%**
Kaiser Permanente HMO – General County (with hearing aids) [1]			
Employee Only	$585.13	$631.87	
Employee + Spouse	1,170.26	1,263.74	
Employee + Children	1,053.23	1,137.36	
Employee + Family	1,755.39	1,895.60	
Composite	$1,268.61	$1,369.95	**8.0%**
Kaiser Permanente HMO – POA [1]			
Employee Only	$582.94	$629.68	
Employee + Spouse	1,165.88	1,259.37	
Employee + Children	1,049.29	1,133.43	
Employee + Family	1,748.82	1,889.05	
Composite	1,440.11	1,555.58	**8.0%**

	Rates PEPM		
	2013	2014	% Change
Providence Retirees - $1000 Deductible [1]			
Retiree Only	$541.45	$581.78	**7.4%**
Retiree + Spouse	1,082.98	1,163.64	
Retiree + Children	974.60	1,047.19	
Retiree + Family	1,624.36	1,745.35	
Kaiser Permanente Retirees – General County $1000 Deductible [1]			
Retiree Only	$439.64	$474.90	**8.0%**
Retiree + Spouse	879.28	949.80	
Retiree + Children	791.35	854.83	
Retiree + Family	1,318.96	1,424.75	
Kaiser Permanente Retirees – POA $1000 Deductible [1]			
Retiree Only	$439.70	$474.96	**8.0%**
Retiree + Spouse	879.39	949.92	
Retiree + Children	791.46	854.92	
Retiree + Family	1,319.14	1,424.93	
Kaiser Permanente Medicare Retirees [1]			
Retiree Only (GC)	$337.64	$346.30	**2.6%**
Retiree Only (POA)	$332.07	$340.74	**2.6%**
Dental Plans			
Moda (formerly ODS)			
Administration	$6.02	$6.02	**0.0%**
Incentive Plan - General County			
Employee Only	$76.00	$83.00	
Employee + Spouse	153.00	$167.00	
Employee + Children	108.00	$118.00	
Employee + Family	185.00	$201.00	
Composite	143.00	$156.00	**9.1%**
Incentive Plan - POA			
Employee Only	$76.00	$74.00	
Employee + Spouse	$153.00	$148.00	
Employee + Children	$108.00	$105.00	
Employee + Family	$185.00	$179.00	
Composite	143.00	$138.00	**-3.5%**
50% Plan – General County Only			
Employee Only	$36.00	$38.00	
Employee + Spouse	71.00	$74.00	
Employee + Children	50.00	$52.00	
Employee + Family	84.00	$87.00	
Composite	67.00	$70.00	**4.5%**
Preventive Plan – General County Only			
Employee Only	$72.00	$70.00	
Employee + Spouse	145.00	$141.00	
Employee + Children	104.00	$101.00	
Employee + Family	176.00	$171.00	
Composite	138.00	$134.00	**-2.9%**

	Rates PEPM		
	2013	2014	% Change
Kaiser Permanente[1]			
Employee Only	$83.56	$85.95	
Employee + Spouse	165.45	170.18	
Employee + Children	115.31	118.61	
Employee + Family	198.04	203.70	
General County Composite	156.19	160.65	**2.9%**
Life and AD&D – MetLife			
Basic Life (Rate per $1,000 benefit)			
Nonrepresented – General County Only	$0.264	$0.211	**-20.1%**
Represented – General County and POA	0.246	0.197	**-19.9%**
Group Universal Life	Age rated	Age rated	**-20.0%**
Dependent Life per Employee (Rate per Family)			
$5,000 per Dependent – General County	$2.66	$2.39	**-10.2%**
$2,000 per Dependent – POA	0.42	0.38	**-9.5%**
Voluntary AD&D – General County Only (Rate per $1,000 benefit)			
Employee Only	$0.050	$0.040	**-20.0%**
Employee and Family	0.075	0.060	**-20.0%**
LTD – The Standard Insurance			
Self Insured – General County			
Funding Rate (Rate per $100 covered salary)	$0.18	$0.15	**-16.7%**
General Fee (Rate per Employee)	0.32	0.32	**0.0%**
New Claim Fee (Rate per Claim)	334.00	334.00	**0.0%**
Open Claim Fee (Rate per Claim)	16.00	16.00	**0.0%**
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 – Part Time 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 – UnumProvident – General County Only			
Monthly Rate per Participant	Age rated	Age rated	**0.0%**

[1]*Rates include the standard 2014 contract changes.*

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Providence Health Plan

General County

The preliminary proposed 2014 rate increases provided by Providence Health Plan were 8.8% and 7.2%, depending on the plan, over the 2013 rates. After updating the renewal calculation with June claims experience and negotiating with Mercer, Providence reduced the 2014 renewal increase to 4.0% to the Open Option plan and 4.9% to the Person Option plan.

Providence's renewal included required legislative changes. Additionally, Providence moved their vision benefit administration to VSP. As a result of this change, benefits will enhance slightly for all members.

The BRC elected no plan changes for the 2014 plan year.

The County renewed the medical, vision, and prescription drug plans with Providence effective January 1, 2014.

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

Exhibit B(1) contains the required 2014 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2014.

See **Exhibit C** for the Providence 2014 General County benefit summaries, including a summary illustrating the new vision plan.

The 2014 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 $500 Common Deductible

	Medical/ Prescription	Premier Vision	Total
Actives, Job Share, COBRA[1], & Early Retiree			
Employee Only	$618.10	$11.32	$629.42
Employee + Spouse	1,236.28	22.64	$1,258.92
Employee + Children	1,112.56	20.38	$1,132.94
Employee + Family	1,854.31	33.96	$1,888.27
Composite			$1,379.99

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

Open Option 15/10/30/2000 $500 Common Deductible with Hearing Aids

	Medical/ Prescription	Premier Vision	Hearing Aids $1,500	Total
Actives, Job Share, COBRA[1], & Early Retiree				
Employee Only	$625.62	$11.32	$3.02	$639.96
Employee + Spouse	1,251.31	22.64	6.04	1,279.99
Employee + Children	1,126.09	20.38	5.44	1,151.91
Employee + Family	1,876.96	33.96	9.06	1,919.88
Composite				$1,390.29

Peace Officers

The preliminary proposed 2014 rate increases from Providence were 9.3% and 3.4% over the 2013 rates. After the projection was updated with June claims experience, Providence reduced the 2014 renewal to 4.7% to the Open Option plan and 1.0% to the Personal Option plan.

The County renewed the medical, vision, and prescription drug plans with Providence effective January 1, 2014. There were no plan changes, other than the required changes, for the 2014 plan year.

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

The standard 2014 contract changes summary for grandfathered plans in **Exhibit B(2)** apply to the POA plans. The change to VSP also applied to the POA plans as well.

See **Exhibit C** for the Providence 2014 POA benefit summaries.

The 2014 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	Basic Vision	Total
Actives, Job Share, COBRA[1], & Early Retiree			
Employee Only	$658.26	$7.54	$665.80
Employee + Spouse	1,316.61	15.08	1,331.69
Employee + Children	1,184.85	13.57	1,198.42
Employee + Family	1,974.79	22.62	1,997.41
Composite			1,612.73

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

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

	Medical/Prescription	Basic Vision	Total
Actives, Job Share, COBRA, & Early Retiree			
Employee Only	$677.07	$7.54	$684.61
Employee + Spouse	1,354.23	15.08	1,369.31
Employee + Children	1,218.71	13.57	1,232.28
Employee + Family	2,031.22	22.62	2,053.84
Composite			1,666.25

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 increase of 7.4%.

Exhibit B contains the standard 2014 contract changes for grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2014 early retiree benefit summaries.

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

The 2014 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[1]
Employee Only	$581.78
Employee + Spouse	1,163.64
Employee + Children	1,047.19
Employee + Family	1,745.35

Medicare-Eligible retirees (age 65 and older) are eligible for the Medicare Group Extra plan and Supplement Plan F. Due to mandated CMS changes, the Medicare plan has been updated to

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

match current federally mandated plan parameters. The 2014 benefit summary is included in **Exhibit C**.

The 2014 premium rates for the Medicare Group Extra plan and Supplemental Plan F plan are shown below as PEPM, and include the required contract changes for the plans:

Medicare Extra and Supplement Plans

Medicare Group Extra With Prescription Drug	$244.00
Medical Supplement Plan F Total	617.50
Medical	369.11
Prescription Drug	248.39

Kaiser Permanente

General County and Peace Officers

Kaiser initially proposed an overall 9.1% increase to the 2013 premium rates. After Mercer's negotiations with Kaiser, Kaiser reduced their overall renewal increase to 8.0%.

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, 2014.

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

Exhibit E contains the 2014 contract changes provided by Kaiser. The BRC and POA accepted the proposed 2014 benefit and administrative clarifications. These plans are considered grandfathered, and, therefore, the proposed benefit changes do not apply.

See **Exhibit F** for the Kaiser 2014 benefit summaries.

The 2014 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	$631.87
Employee + Spouse	1,263.74
Employee + Children	1,137.36
Employee + Family	1,895.60
Composite	1,369.95

Peace Officers Association	
Employee Only	$629.68
Employee + Spouse	1,259.37
Employee + Children	1,133.43
Employee + Family	1,889.05
Composite	1,555.58

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 increase of 8.0% was accepted by the County.

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

Exhibit E contains the 2014 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2014 benefit summaries.

The 2014 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	$474.90
Employee + Spouse	949.80
Employee + Children	854.83
Employee + Family	1,424.75
Peace Officers Association	
Employee Only	$474.96
Employee + Spouse	949.92
Employee + Children	854.92
Employee + Family	1,424.93
Medicare (Parts A, B and D)	
Retiree Only (GC)	$346.30
Retiree Only (POA)	$340.74

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

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 first year of a three-year administrative fee guarantee. The administration fee increase for the three-year period will be as follows:

Rates per Employee per Month	2014	2015	2016
Administration fee	$6.02	$6.10	$6.18
% Change	0.00%	1.35%	1.35%

The County renewed the dental administration services with Moda effective January 1, 2014 with the following plan changes to the plans:

- Add the iodine and Arestin periodontal cleaning treatment coverage to all three plans (Incentive, Preventive and Constant).
- Add Foster Children as eligible dependents.
- Include coverage for domestic partners under any legal registry in the US.
- The County instituted an employee dental contribution.

The BRC elected to increase the annual benefit maximum on the General County Incentive and Constant plans to $2,000.

Exhibit G contains the Moda administrative contract changes for 2014, which were accepted.

See **Exhibit H** for the 2014 Moda benefit summaries.

Underwriting

Mercer projected a 2014 funding decrease of 3.1% for the 2014 self-insured dental plans. **Exhibit I** includes the underwriting calculation.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2012, through June 30, 2013. 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 2014 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	$83.00
Employee + Spouse	167.00
Employee + Children	118.00
Employee + Family	201.00
Composite	156.00

Incentive Plan – POA	
Employee Only	$74.00
Employee + Spouse	148.00
Employee + Children	105.00
Employee + Family	179.00
Composite	138.00

50% Plan – General County Only	
Employee Only	$38.00
Employee + Spouse	74.00
Employee + Children	52.00
Employee + Family	87.00
Composite	70.00

Preventive Plan – General County Only	
Employee Only	$70.00
Employee + Spouse	141.00
Employee + Children	101.00
Employee + Family	171.00
Composite	134.00

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 2.9% increase to the 2013 premium rates.

The BRC and POA did not make any benefit changes for 2014. The County renewed the dental plan with Kaiser Permanente effective January 1, 2014.

Exhibit E contains the 2014 standard contract changes provided by Kaiser, which will be effective January 1, 2014.

See **Exhibit F** for the Kaiser 2014 benefit summaries.

The 2014 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	$85.95
Employee + Spouse	170.18
Employee + Children	118.61
Employee + Family	203.70
Composite	160.65

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 updated rates will be 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	
Nonrepresented 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 2014 plan year.

Fees and Premium Rates

The County is entering the second year of a two-year rate guarantee with Standard. The next renewal will be January 1, 2015.

The 2014 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	$0.15 per $100 covered payroll
Administration Fees	
General	$0.32 PEPM
New Claim	$334 per claim
Open Claim	$16 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 2014 plan year. The County renewed these services with Flex-Plan effective January 1, 2014.

The 2014 fees remain the same as the 2013 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 2014 rates remain unchanged and are age rated. The LTC rates have not changed since the inception of the plan January 1, 2000. Unum noted that they have submitted a rate increase to the Oregon State Insurance Division and were approved for a 15% increase to the LTC rates for 2015.

3

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 implemented a Dental contribution for all employees. The Employer and Employee costs along with the cash back for all employees are as follows:

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
NONREPRESENTED				
Moda Preventive				
Employer	$69.00	$140.00	$100.00	$170.00
Employee	1.00	1.00	1.00	1.00
Moda Incentive				
Employer	82.00	166.00	117.00	200.00
Employee	1.00	1.00	1.00	1.00
Moda Constant (50%)				
Cash Back	36.00	78.00	54.00	95.00
Kaiser				
Employer	84.95	169.18	117.61	202.70
Employee	1.00	1.00	1.00	1.00
Dental Opt Out				
Cash Back	37.00	79.00	55.00	96.00
REPRESENTED				
Moda Preventive				
Employer	69.00	140.00	100.00	170.00
Employee	1.00	1.00	1.00	1.00
Moda Incentive				
Employer	82.00	166.00	117.00	200.00
Employee	1.00	1.00	1.00	1.00
Moda Constant (50%)				
Cash Back	71.00	71.00	71.00	71.00
Kaiser				
Employer	84.95	169.18	117.61	202.70
Employee	1.00	1.00	1.00	1.00
Dental Opt Out				
Cash Back	72.00	72.00	72.00	72.00

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	$586.16	$1,252.05	$1,118.78	$1,917.77
Employee	79.64	79.64	79.64	79.64
Providence Open Option				
Employer	602.30	1,287.00	1,149.97	1,971.53
Employee	82.31	82.31	82.31	82.31
Kaiser				
Employer	629.68	1,259.37	1,133.43	1,889.05
Employee	0.00	0.00	0.00	0.00

The County implemented a Dental contribution for all employees. The Employer and Employee costs along with the cash back for all employees are as follows:

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Moda Incentive				
Employer	$73.00	$147.00	$104.00	$178.00
Employee	1.00	1.00	1.00	1.00
Kaiser				
Employer	84.95	169.18	117.61	202.70
Employee	1.00	1.00	1.00	1.00
Dental Opt Out				
Cash Back	72.00	72.00	72.00	72.00

4

Exhibits

- Exhibit A – Providence Health Plans Medical Underwriting
- Exhibit B – Providence Health Plans 2014 Contract Changes
  - Exhibit B(1) – Nongrandfathered
  - Exhibit B(2) – Grandfathered
- Exhibit C – Providence Health Plans Benefit Summaries
- Exhibit D – Kaiser Permanente Medical Underwriting
- Exhibit E – Kaiser Permanente 2014 Contract Changes
- Exhibit F – Kaiser Permanente Benefit Summaries
- Exhibit G – Moda 2014 Contract Changes
- Exhibit H – Moda Benefit Summaries
- Exhibit I – Self-funded Dental Plan Underwriting Calculation

APPENDIX A

Providence Health Plans Medical Underwriting

Account:	CLACKAMAS COUNTY - ACTIVE EARLY RETIREE - UPDATE EXPERIENCE
Group Number:	160112
Account Executive:	B. MINER
Agent Name:	JAN LONG
Effective Date:	1/1/2014 - 12/31/2014
Product(s):	PF $20 20* $1200 $500 Rx#25$ $30 ASH CUST
	Vision Premium Plan
	Spinal Man Acup & Mas Therapy 20 1500 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 Perx Experience Rate Exhibit	7/1/2012 - Capitation	6/30/2013 Medical	Pharmacy	Vision	Chiro / Alt .Care	Total
Paid Claims/Capitation	$729,607	$16,805,693	$2,502,045	$265,166	$222,783	$20,525,294
Pharmacy Rebate	n/a	n/a	-$121,099	n/a	n/a	-$121,099
Benefit Adjustments	$49,047	-$958,570	-$100,640	$10,314	$23,621	-$976,228
Adjusted Non-Pooled Claims	$778,654	$15,847,123	$2,280,306	$275,480	$246,404	$19,427,967
Ending Reserve	n/a	$1,640,104	$61,264	$15,177	$0	
Beginning Reserve	n/a	-$1,238,099	-$28,115	-$16,199	$0	
Incurred Claims	$778,654	$16,249,128	$2,303,455	$274,458	$246,404	$19,652,099
Pooled Claims Credit ($150K)	n/a	-$2,007,526	$0	$0	n/a	
Net Pooled Claims	$778,654	$14,241,602	$2,303,455	$274,458	$246,404	$17,844,573
Annual Trend	8.90%	8.90%	8.50%	2.00%	10.00%	8.76%
Months of Trend	18.0	18.0	18.0	18.0	18.0	
Trend Factor	1.1364	1.1364	1.1302	1.0301	1.1537	
Trended Incurred Claims	$884,883	$16,184,552	$2,603,301	$282,733	$284,274	$20,239,743
Pooling Charge	n/a	$705,302	$0	$0	n/a	
Trended Incurred Claims adjusted for Pooling		$20,378,038		$282,733	$284,274	$20,945,345
Administration		$1,923,805		$29,062	$29,465	$1,982,331
ACA Health Insurance Provider Fee		$198,951		$2,727	$2,744	$204,421
Portability Adjustment		$0		n/a	n/a	$0
State High Risk Reinsurance Fee		$189,571		n/a	n/a	$189,571
Patient-Centered Outcome Research Institute Fee		$7,915		n/a	n/a	$7,915
ACA High Risk Reinsurance Fee		$248,811		n/a	n/a	$248,811
Commission: None		$0		$0	$0	$0
Projected Revenue Requirement		$22,947,090		$314,522	$316,482	$23,578,094
Member Months		47,390		46,839	46,839	47,990
Projected Revenue Requirement (current 12 mos.)		$484.19		$6.72	$6.76	$497.67
Factor to adjust Proj Rev Req (curr 12 mos) to new product		1.016		1.340	1.000	
Projected Revenue Req (curr 12 mos) adjusted to new product		$491.79		$9.01	$6.76	$507.56
Projected Revenue Requirement (current 12 mos.)		$491.79		$9.01	$6.76	$507.56
Projected Revenue Requirement (prior 12 mos.)		$507.46		$8.81	$7.47	$523.74
Projected Revenue Requirement (demographics)		$405.12		$6.92	$2.39	$414.43
Credibility Factor (current 12 mos.)		100.00%		100.00%	0.00%	100.00%
Credibility Factor (prior 12 mos.)		0.00%		0.00%	0.00%	0.00%
Credibility Factor (demographics)		0.00%		0.00%	100.00%	0.00%
Blended Revenue Requirement PMPM		$491.79		$9.01	$2.39	$503.19
Blended Revenue Requirement PMPM modified for 1.5% rate stabilization load		$499.17		$9.15	$2.43	$510.74
Blended Revenue Requirement PMPM		$499.17		$9.15	$2.43	$510.74

Current Enrollment

	Subscribers	Members	Mix	Contract Size	Rate Ratio	Mix x Size	Mix x Ratio
EMPLOYEE	344	344	23.4%	1.000	1.000	0.234	0.234
EE+SPOUSE	380	760	25.9%	2.000	2.000	0.518	0.518
EE+CHILD(REN)	146	306	9.9%	2.781	1.800	0.277	0.179
EE+FAMILY	598	2,401	40.7%	4.015	3.000	1.636	1.222
Total	1,468	3,911	100.0%			2.664	2.153
					Single Rate Multiplier		1.237

Renewal Rates

	Medical/Pharmacy	Vision	Chiro	Total
EMPLOYEE	$617.63	$11.32	$3.00	$631.95
EE+SPOUSE	$1,235.34	$22.64	$6.00	$1,263.98
EE+CHILD(REN)	$1,111.72	$20.38	$5.40	$1,137.50
EE+FAMILY	$1,852.90	$33.96	$9.00	$1,895.86

Account:	CLACKAMAS COUNTY - ACTIVE/EARLY RETIREE - UPDATE EXPERIENCE
Group Number:	100112
Account Executive:	D. MINER
Agent Name:	JAN LONG
Effective Date:	1/1/2014 - 12/31/2014
Product(s):	PE $20/20** $1200/$500 Rx#2/$15/$30 ASH CUST
	Vision Premium Plan
	Spinal Man Arup & Mat Therapy 20/1500-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: 7/1/2011 - 6/30/2012						
Experience Rate Exhibit:	Capitation	Medical	Pharmacy	Vision	Chiro / Alt. Care	Total
Paid Claims Period: 201107 - 201206						
Paid Claims/Capitation	$704,245	$14,840,591	$2,626,342	$247,867	$221,223	$18,539,267
Pharmacy Rebate	n/a	n/a	-$122,227	n/a	n/a	-$122,227
Benefit Adjustments	$42,630	-$924,666	-$96,408	$11,041	$25,863	-$941,540
Adjusted Non-Pooled Claims	$746,875	$13,915,925	$2,306,707	$258,908	$247,086	$17,475,500
Ending Reserve	n/a	$1,238,099	$28,115	$16,159	$0	
Beginning Reserve	n/a	-$1,255,923	-$70,135	-$12,607	$0	
Incurred Claims	$746,875	$13,898,101	$2,264,687	$262,500	$247,086	$17,419,248
Pooled Claims Credit ($150K)	n/a	-$257,902	$0	$0	n/a	
Net Pooled Claims	$746,875	$13,640,200	$2,264,687	$262,500	$247,086	$17,161,347
Annual Trend	8.50%	8.50%	8.50%	2.00%	10.00%	8.40%
Months of Trend	30	30	30	30	30	
Trend Factor	1.2262	1.2262	1.2206	1.0568	1.2691	
Trended Incurred Claims	$915,845	$16,726,115	$2,764,262	$275,822	$313,566	$20,995,610
Pooling Charge	n/a	$784,927	$0	$0	n/a	
Trended Incurred Claims adjusted for Pooling		$21,111,149		$275,822	$313,566	$21,700,537
Administration		$1,942,252		$28,361	$32,501	$2,003,104
ACA Health Insurance Provider Fee		$205,516		$2,660	$3,027	$211,204
Portability Adjustment		$0		n/a	n/a	$0
State High Risk Reinsurance Fee		$189,470		n/a	n/a	$189,470
Patient-Centered Outcome Research Institute Fee		$7,910		n/a	n/a	$7,910
ACA High Risk Reinsurance Fee		$248,679		n/a	n/a	$248,679
Commission: None		$0		$0	$0	$0
Projected Revenue Requirement		$23,704,977		$306,834	$349,093	$24,360,904
Member Months		47,367		46,702	46,702	47,367
Projected Revenue Requirement (prior 12 mos.)		$500.45		$6.57	$7.47	$514.49
Factor to adjust Proj Rev Req (prior 12 mos) to new product		1.014		1.340	1.000	
Projected Revenue Req (prior 12 mos) adjusted to new product		$507.46		$8.81	$7.47	$523.74

APPENDIX B

Providence Health Plans 2014 Contract Changes

Exhibit B(1) – Nongrandfathered Plans (General County)

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison

Applies to Non-Grandfathered: Personal, Open, Value Based, HSA, Core, Traditional, Medical Home (Choice), Medical Neighborhood (Connect)

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
* Section numbers and language reflect Open Option unless otherwise indicated. *Underlined text denotes new language added to member handbooks.					
Personal, Open, Value Based and Traditional Option PHP Change Change to comply with the ACA mandate.	Member Handbooks and Benefit Summaries	Separate handbooks for grandfathered and non-grandfathered plans.	The same handbook is used for non-grandfathered and grandfathered plans.	Separate handbooks will be provided for non-grandfathered and grandfathered plans.	Administrative Change
		Family accumulators change from three (3) times the individual to two (2) times the individual.	Family accumulators are 3 times the individual.	Non-grandfathered plans have family accumulators that are 2 times the individual.	Benefit Change
		Deductible now applies to the out-of-pocket maximum.	Deductible does not apply to out-of-pocket maximum.	Deductible applies to out-of-pocket maximum. Pharmacy benefits and any other essential health benefits apply to the out-of-pocket maximum.	
		Provider non-discrimination rules apply to non-grandfathered plans.	Provider discrimination allowed.	Provider non-discrimination rules apply. (See pages 2 & 3)	
Core Plan PHP Changes Change to comply with the ACA mandate.	Member Handbooks and Benefit Summaries	Coinsurance maximum is replaced with out-of-pocket maximum.	Coinsurance accumulated to a Calendar year common coinsurance maximum.	Removing coinsurance maximum and replacing with out-of-pocket maximum.	Administrative Change
			Includes three (3) plan designs. Essentials, Advantages, and Alternatives.	Includes two (2) plan designs: Essentials and Advantages.	Benefit Change
		Family accumulators change from three (3) times the individual to two (2) times the individual.	Family accumulators are three (3) times the individual.	Non-grandfathered plans have family accumulators that are two (2) times the individual.	
		Deductible now applies to the out-of-pocket maximum.	Deductible does not apply to out-of-pocket maximum.	Deductible applies to out-of-pocket maximum. Pharmacy benefits and any other essential health benefits apply to the out-of-pocket maximum.	
		Provider non-discrimination rules apply.	Provider discrimination allowed.	Provider non-discrimination rules apply. (See pages 2 & 3)	

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison

Applies to Non-Grandfathered: Personal, Open, Value Based, HSA, Core, Traditional, Medical Home (Choice), Medical Neighborhood (Connect)

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
HSA PHP Change Change to comply with ACA cost-share requirements.	Member Handbooks and Benefit Summaries	Separate handbooks for grandfathered and non-grandfathered plans. Provider non-discrimination rules apply to non-grandfathered plans.	The same handbook is used for non-grandfathered and grandfathered plans. Provider discrimination allowed.	Separate handbooks will be provided for non-grandfathered and grandfathered plans. Provider non-discrimination rules apply. (See pages 2 & 3)	Administrative Change Benefit Change
Medical Home (Choice) New Plan	Member Handbooks and Benefit Summaries	Introducing Medical Home	Not applicable	Medical Home plan requires designation of a Medical Home and referral from the Medical Home to see participating providers for in-plan benefits. Out-of-plan benefit available for services received from non-participating providers or without a referral. Service area (selling area) is slightly smaller than the Providence's standard service area.	New Plan
Medical Neighborhood (Connect) New Plan	Member Handbooks and Benefit Summaries	Introduction Medical Neighborhood	Not applicable	Medical Neighborhood plan is similar in design to Medical Home, but is only offered in 3 counties: Washington, Multnomah and Clackamas. Requires designation of a Medical Neighborhood and referral from the Medical Neighborhood to see network providers using in-network benefits. Out-of-network benefit available for services received from non-network providers or without a referral. Note: "network providers" means providers that participate in the Medical Neighborhood Network – a subset of Providence's Participating Provider Network.	New Plan
All categories of licensed providers (Provider Non-Discrimination)	Member Handbooks and Benefit Summaries	ACA requires plans to cover services from all provider types licensed in the state if the plan otherwise covers the service.	Services received from certain providers, such as chiropractors, naturopaths and acupuncturists, are not covered unless coverage is added by separate endorsement as a Supplemental Benefit.	In compliance with the ACA, all references to excluding coverage from certain provider types, such as chiropractors, naturopaths and acupuncturists, are removed. If a service is covered under the plan, and if the service is within the licensed provider's scope of practice, the service will be covered under the plan. (Continued on next page)	Administrative Change Benefit Change

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison

Applies to Non-Grandfathered: Personal, Open, Value Based, HSA, Core, Traditional, Medical Home (Choice), Medical Neighborhood (Connect)

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
ACA Mandate				Note: Spinal manipulation and acupuncture are covered only under the separate limited Spinal Manipulation and Acupuncture benefit. Nothing in this provision requires the Plan to contract with the provider type. If the provider is not participating with the Plan, the service will be covered under out-of-plan benefits.	
Prescription Drug Benefit ACA Mandate	Member Handbooks and Benefit Summaries.	ACA defines prescription drug benefits as an essential health benefit.	For all plans except HSA: Prescription drug benefits are available by endorsement as a Supplemental Benefit, are not subject to the medical deductible and do not apply to the medical out-of-pocket maximum. For HSA plans: Prescription drug benefits are integrated with the medical plan, are subject to the deductible and accumulate to the out-of-pocket maximum.	For all plans except HSA: If a prescription drug endorsement is purchased, any member cost share must be applied to the out-of-pocket maximum, including any prescription drug deductible (note: none of the standard pharmacy designs include a prescription drug deductible). For HSA plans: There is no change to this plan.	Administrative Change Benefit Change
Approved Clinical Trials ACA Mandate	Member Handbooks	ACA requires coverage of certain services related to approved clinical trials.	Coverage would be provided only for those services not related to the clinical trial.	3.8 APPROVED CLINICAL TRIALS Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial. If your Approved Clinical Trial is available through both Participating and Non-Participating providers, Providence will require you to participate through a Participating Provider. Covered Services include the routine patient costs for items and services received in connection with the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services under the Plan. The following costs are excluded: • The cost of the investigational item, device or service; • The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and	Benefit Change

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
				• The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for services unrelated to a clinical trial to the extent that the services are otherwise Covered Services under the Plan.	
Supplemental Alternative Care and Chiropractic Care Benefits **Spinal Manipulation & Acupuncture Benefit** PHP Change	Member Handbooks and Benefit Summaries	Removing supplemental benefit options for alternative and chiropractic care. Replacing with combined limited Spinal Manipulation-Acupuncture Benefits.	For all plans except HSA: • Endorsements for chiropractic only and alternative care (chiropractic, acupuncture, naturopathy) are available. • Services are not subject to a deductible and copays or coinsurance does not apply to the out-of-pocket maximum. • Options with variable copays, coinsurance and benefit maximums are available. HSA plans: • Spinal manipulation and acupuncture is currently integrated with the medical plan, as well as services for Naturopathy. • Services are subject to the deductible, and coinsurance applies to the out-of-pocket maximum. • Benefits are limited to $500 and are subject to 20% coinsurance.	For all plans including HSA: • Chiropractic and alternative care endorsements are replaced with the Spinal Manipulation and Acupuncture benefit. • Spinal Manipulation and Acupuncture benefit is limited to $500 with the choice of $15 or $25 copays. Buy up options are available. • For coverage related to naturopathy, please refer to pages 2 & 3, under the topic of All Categories of Licensed Providers. For all plans except HSA: • Deductible does not apply, and the copay or coinsurance does not apply to the out-of-pocket maximum. HSA plans: • Deductible applies, and the copay or coinsurance applies to the out-of-pocket maximum.	Benefit Change Clarification

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison

Applies to Non-Grandfathered: Personal, Open, Value Based, HSA, Core, Traditional, Medical Home (Choice), Medical Neighborhood (Connect)

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
Prior Authorization PHP Changes	Member Handbooks	Revisions to covered services that require Prior Authorization list.	4.4 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION *** Services requiring prior authorization: • All inpatient admissions to a hospital (not including emergency room care), skilled nursing facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all hospital and birthing center admissions for maternity/delivery services; • All outpatient surgical procedures; • All inpatient, residential and day or partial hospitalization treatment services for mental health and chemical dependency conditions, as provided in section 5.7; • All human organ/tissue transplant services, as provided in 6.1; • All restoration of head/facial structures; limited dental services as provided in section 6.2; • All PET, CT, CTA, MRI and MRA imaging and nuclear cardiac study services as provided in section 5.9.6; • All home health care services as provided in section 5.9.12; • All hospice care services as provided in section 5.9.13; • All medical supplies, medical appliances, prosthetic and orthotic devices, durable medical equipment and hearing aids in excess of $1,500 as provided in section 5.8; and • All outpatient hospitalization and anesthesia for dental services as provided in section 6.2.2; • All outpatient cardiac rehabilitation services as provided in section 5.9.1. ***	3.5 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION *** Services requiring Prior Authorization: • All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all Hospital and birthing center admissions for maternity/delivery Services; • All outpatient surgical procedures; • All inpatient, residential and day or partial hospitalization treatment Services for Mental Health and Chemical Dependency conditions, as provided in section 4.9, • All Human Organ/Tissue Transplant Services, as provided in 4.10; • All Restoration of Head/Facial Structures: Limited Dental Services as provided in section 4.8.9; • All High Tech Imaging, including PET, CT, CTA, MRI and MRA imaging and Nuclear Cardiac Study Services as provided in section 4.8.1; • All Home Health Care Services as provided in section 4.8.11; • All Hospice Care Services as provided in section 4.8.12; • All Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment and Hearing Aids in excess of $1,500 as provided in section 4.7; and • All outpatient hospitalization and anesthesia for dental Services as provided in section 4.8.9; • All outpatient cardiac rehabilitation Services as provided in section 4.8.3. • All Services for Genetic Testing and Counseling as provided in	Administrative Change

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
				section 4.8.4; • Certain medications, including certain immunizations, received in your Provider's office as provided is sections 4.1.4 and 4.2.2; and • If your plan includes Prescription Drug Supplemental Benefits, Certain Prescription Drugs specified in our Formulary as provided in section 13.1. ***	
Hearing Aids ACA and Oregon Mandate	Member Handbooks	Removing dollar limit.	**5.8.5 Hearing Aids** Medically Necessary external hearing aids and devices, one per ear, prescribed by a licensed audiologist and received from an approved provider are covered for Members 18 years of age or younger, and Members 19 to 25 years of age if enrolled in secondary school or an accredited educational institution. "Hearing aids and devices" are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. Coverage is limited to $4,000 every four years. This limit will be adjusted January 1st of each calendar year to reflect the U.S. City Average Consumer.Price Index.	**5.8.5 Hearing Aids** Medically Necessary external hearing aids and devices, one per ear, prescribed by a licensed audiologist and received from an approved provider are covered for Members 18 years of age or younger, and Members 19 through to 25 years of age if enrolled in secondary school or an accredited educational institution. "Hearing aids and devices" are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. ~~Coverage is limited to $4,000 every four years. This limit will be adjusted January 1st of each calendar year to reflect the U.S. City Average Consumer Price Index.~~	Benefit Change
Vision Supplemental Benefit PHP Change	Member Handbooks and Benefit Summaries	Changing Vision administrator to VSP. Replacing existing plans with new VSP options.	Vision benefit administered by PHP. Several product options for exam and hardware with dollar limits. Coverage every 24 months for adults, every 12 months for children.	All vision plans are administered by VSP. 4 new benefit options available. See benefit summaries for coverage details.	Administrative Change Benefit Change
Portability Oregon Sunset on Portability requirement.	Member Handbooks	Removal of Portability, per Oregon regulation.	**12. PORTABILITY** **(section explains Oregon Portability coverage)**	Portability coverage is no longer offered. Individual coverage is available through PHP Individual & Family Plans and/or Cover Oregon.	Benefit Sunset

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison

Applies to Non-Grandfathered: Personal, Open. Value Based, HSA, Core, Traditional, Medical Home (Choice), Medical Neighborhood (Connect)

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
Gender Identity Non-Discrimination Oregon Non-Discrimination Requirement	Member Handbooks	Changing language to comply with *Oregon gender identity* non-discrimination requirements.	5. EXCLUSIONS *Exclusions that apply to* Reproductive Services: • All Services related to sexual disorders or dysfunctions regardless of gender or cause, including all Services related to a sex-change operation, including evaluation, surgery and follow-up Services; * * * 16 Definitions Mental Health Mental Health means Services related to all disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for: • Diagnostic codes 317, 318.0, 318.1, 318.2 and 319 relating to Mental Retardation; • Diagnostic codes 315.00, 315.1, 315.2 and 315.9 relating to Learning Disorders; • Diagnostic codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89 and 302.9 relating to Paraphilias; • Diagnostic codes 302.6, 302.85 and 302.9 relating to Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and • Diagnostic codes V15.81 through V71.09, "V" codes. This exception does not extend to children five years of age or younger for diagnostic codes V61.20 (Parent-Child Relational Problem) through V61.21 (Neglect, Physical Abuse or Sexual Abuse of Child) and V62.82 (Bereavement).	5. EXCLUSIONS Exclusions that apply to Reproductive Services: • All services related to sexual disorders or dysfunctions regardless of gender or cause~~, including all Services related to a sex-change operation, including evaluation, surgery and follow-up Services~~; * * * 14 Definitions Mental Health Mental Health means Services related to all disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for: • Diagnostic codes 317, 318.0, 318.1, 318.2 and 319 relating to Mental Retardation; • Diagnostic codes 315.00, 315.1, 315.2 and 315.9 relating to Learning Disorders; • Diagnostic codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89 and 302.9 relating to Paraphilias; and • ~~Diagnostic codes 302.6, 302.85 and 302.9 relating to Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and~~ • Diagnostic codes V15.81 through V71.09, "V" codes. This exception does not extend to children five years of age or younger for diagnostic codes V61.20 (Parent-Child Relational Problem) through V61.21 (Neglect, Physical Abuse or Sexual Abuse of Child) and V62.82 (Bereavement).	Benefit Change

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in January 2014 documents)	Change Type
			15.1.9 Prescription Drug Exclusions *** 21. Drugs or medicines 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; ***	**13.1.9 Prescription Drug Exclusions** *** 20. Drugs or medicines 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~~; ***	
60 day Member Prior Notice Requirement ACA Mandate	Member Handbooks	Clarifies that the plan cannot be changed outside of the renewal without providing 60 days prior notice to Members.	**14.1 AMENDMENT OF THE GROUP CONTRACT** The provisions of the Group Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the Employer and us. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Employer if we have provided written notice of the amendment to the Employer prior to the payment of such Premium.	**AMENDMENT OF THE GROUP CONTRACT** The provisions of the Group Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the Employer and us. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Employer if we have provided written notice of the amendment to the Employer prior to the payment of such Premium. Outside of renewal or as required by Oregon state or federal mandate, no material modification will be made to benefits, including preventive benefits, without providing notice to Members 60 days in advance of the effective date.	Administrative Change

Exhibit B(2) – Grandfathered Plans (POA)

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison
Applies to Grandfathered: Personal, Open, Value Based, HSA, Traditional Option

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in new January 2014 documents)	Change Type
* Section numbers and language reflect Open Option unless otherwise indicated. * Underlined text denoted new language added to member handbooks.					
Personal, Open, Value Based, HSA and Traditional Option PHP Change Change to provider discrimination to comply with ACA requirements.	Member Handbooks	Separate handbooks for Grandfathered and Non-Grandfathered plans. Provider discrimination allowed for Grandfathered Plans	The same handbook is used for non-grandfathered and grandfathered plans. Provider discrimination allowed for non-grandfathered and grandfathered plans.	Separate handbooks will be provided for non-grandfathered and grandfathered plans. Provider discrimination allowed for grandfathered plans.	Administrative Change
Prior Authorization PHP Change	Member Handbooks	Revisions to covered services that require Prior Authorization list.	4.4 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION ... Services requiring prior authorization: • All inpatient admissions to a hospital (not including emergency room care), skilled nursing facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all hospital and birthing center admissions for maternity/delivery services; • All outpatient surgical procedures; • All inpatient, residential and day or partial hospitalization treatment services for mental health and chemical dependency conditions, as provided in section 5.7; • All human organ/tissue transplant services, as provided in 6.1; • All restoration of head/facial structures; limited dental services as provided in section 6.2; • All pet, ct, cta, mri and mra imaging and nuclear cardiac study services as provided in section 5.9.8;	4.4COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION ... Services requiring Prior Authorization: • All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all Hospital and birthing center admissions for maternity/delivery Services; • All outpatient surgical procedures; • All inpatient, residential and day or partial hospitalization treatment Services for Mental Health and Chemical Dependency conditions, as provided in section 4.9; • All Human Organ/Tissue Transplant Services, as provided in 4.10; • All Restoration of Head/Facial Structures; Limited Dental Services as provided in section 4.8.9; • All High Tech Imaging, including PET, CT, CTA, MRI and MRA	Administrative Change

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in new January 2014 documents)	Change Type
			• All home health care services as provided in section 5.9.12; • All hospice care services as provided in section 5.9.13; • All medical supplies, medical appliances, prosthetic and orthotic devices. durable medical equipment and hearing aids in excess of $1,500 as provided in section 5.8; and • All outpatient hospitalization and anesthesia for dental services as provided in section 6.2.2; • All outpatient cardiac rehabilitation services as provided in section 5.9.1. ***	imaging and Nuclear Cardiac Study Services as provided in section 4.8.1; • All Home Health Care Services as provided in section 4.8.11; • All Hospice Care Services as provided in section 4.8.12; • All Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment and Hearing Aids in excess of $1,500 as provided in sect on 4.7; and • All outpatient hospitalization and anesthesia for dental Services as provided in section 4.8.9; • All outpatient cardiac rehabilitation Services as provided in section 4.8.3. • All Services for Genetic Testing and Counseling as provided in section 4.8.4; • Certain medications, including certain immunizations, received in your Provider's office as provided is sections 4.1.4 and 4.2.2; and • If your plan includes Prescription Drug Supplemental Benefits, Certain Prescription Drugs specified in our Formulary as provided in section 13.1. ***	
Hearing Aids ACA and Oregon Mandate	Member Handbooks	Removing dollar limit.	***5.8.5 Hearing Aids*** Medically Necessary external hearing aids and devices, one per ear, prescribed by a licensed audiologist and received from an approved provider are covered for Members 18 years of age or younger, and Members 19 to 25 years of age if enrolled in secondary school or an accredited educational institution. "Hearing aids and devices" are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. Coverage is limited to $4,000 every four years. This limit will be adjusted January 1st of each calendar year to reflect the U.S. City Average Consumer Price Index.	**5.8.5 Hearing Aids** Medically Necessary external hearing aids and devices, one per ear, prescribed by a licensed audiologist and received from an approved provider are covered for Members 18 years of age or younger, and Members 19 through ~~to~~ 25 years of age if enrolled in secondary school or an accredited educational institution. "Hearing aids and devices" are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. ~~Coverage is limited to $4,000 every four years. This limit will be adjusted January 1st of each calendar year to refect the U.S. City Average Consumer Price Index.~~	Benefit Change

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison

Applies to Grandfathered: Personal, Open, Value Based, HSA, Traditional Option

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in new January 2014 documents)	Change Type
Vision Supplemental Benefit PHP Change	Member Handbooks and Benefit Summaries	Changing Vision administrator to VSP. Replacing existing plans with new VSP options.	Vision benefit administered by PHP. Several product options for exam and hardware with dollar limits. Coverage every 24 months for adults, every 12 months for children.	All vision plans are administered by VSP. 4 new benefit options available. See benefit summaries for coverage details.	Administrative Change Benefit Change
Portability Oregon Sunset on Portability requirement.	Member Handbooks	Removal of Portability per Oregon regulation.	**12. PORTABILITY** **(section explains Oregon Portability coverage)**	Portability coverage no longer offered on any plans. Individual coverage is available through PHP Individual & Family Plans and/or Cover Oregon.	Product Sunset
Gender Identity Non-Discrimination Oregon Non-Discrimination requirement.	Member Handbooks	Changing language to comply with gender identity non-discrimination	**5. EXCLUSIONS** **Exclusions that apply to <u>Reproductive Services</u>:** • All Services related to sexual disorders or dysfunctions regardless of gender or cause, including all Services related to a sex-change operation, including evaluation, surgery and follow-up Services; • • • **16 Definitions** **<u>Mental Health</u>** Mental Health means Services related to all disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for: • Diagnostic codes 317, 318.0, 318.1, 318.2 and 319 relating to Mental Retardation; • Diagnostic codes 315.00, 315.1, 315.2 and 315.9 relating to Learning Disorders; • Diagnostic codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89 and 302.9 relating to Paraphilias; • Diagnostic codes 302.6, 302.85 and 302.9 relating to	**5. EXCLUSIONS** **Exclusions that apply to <u>Reproductive Services</u>:** • All services related to sexual disorders or dysfunctions regardless of gender or cause~~, including all Services related to a sex-change operation, including evaluation, surgery and follow-up Services~~; • • • **14 Definitions** **<u>Mental Health</u>** Mental Health means Services related to all disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for: • Diagnostic codes 317, 318.0, 318.1, 318.2 and 319 relating to Mental Retardation; • Diagnostic codes 315.00, 315.1, 315.2 and 315.9 relating to Learning Disorders; • Diagnostic codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89 and 302.9 relating to Paraphilias; <u>and</u> • ~~Diagnostic codes 302.6, 302.85 and 302.9 relating to~~	Benefit Change

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in new January 2014 documents)	Change Type
			Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and • Diagnostic codes V15.81 through V71.09, "V" codes. This exception does not extend to children five years of age or younger for diagnostic codes V61.20 (Parent-Child Relational Problem) through V61.21 (Neglect, Physical Abuse or Sexual Abuse of Child) and V62.82 (Bereavement). **15.1.9 Prescription Drug Exclusions** *** 21. Drugs or medicines 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; ***	~~Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and~~ • Diagnostic codes V15.81 through V71.09, "V" codes. This exception does not extend to children five years of age or younger for diagnostic codes V61.20 (Parent-Child Relational Problem) through V61.21 (Neglect, Physical Abuse or Sexual Abuse of Child) and V62.82 (Bereavement). **13.1.9 Prescription Drug Exclusions** *** 20. Drugs or medicines 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~~; ***	
60 day Member Prior Notice Requirement ACA Mandate	Member Handbooks	Adding language that states plan cannot be changed outside of renewal without providing 60 days prior notice to Members.	**14.1 AMENDMENT OF THE GROUP CONTRACT** The provisions of the Group Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the Employer and us. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Employer if we have provided written notice of the amendment to the Employer prior to the payment of such Premium.	**14.1 AMENDMENT OF THE GROUP CONTRACT** The provisions of the Group Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the Employer and us. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Employer if we have provided written notice of the amendment to the Employer prior to the payment of such Premium. Outside of renewal or as required by Oregon state or federal mandate, no material modification will be made to benefits, including preventive benefits, without providing notice to Members 60 days in advance of the effective date.	Administrative Change

08-2012 to 01-2014 Oregon Large Group High Level Contract Comparison
Applies to Grandfathered: Personal, Open, Value Based, HSA, Traditional Option

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in new January 2014 documents)	Change Type
Dependent Eligibility ACA Mandate	Member Handbooks This information was previously referenced in the grand-fathered plan amendment.	Grandfathered plans can no longer exclude dependent children who have coverage through an employer or spouse's employer.	**16 Definitions** **Eligible Family Dependent** Eligible Family Dependent means: 1. The legally recognized spouse or Domestic Partner of a Subscriber; 2. In relation to a Subscriber, the following individuals: a) A biological child, step-child, or legally adopted child; b) An unmarried grandchild for whom the Subscriber or the Subscriber's spouse provides at least 50% support; c) A child placed for adoption with the Subscriber or Subscriber's spouse; d) An unmarried individual for whom the Subscriber or the Subscriber's spouse is a legal guardian and for whom the Subscriber or the Subscriber's spouse provides at least 50% support; and e) A child whom the Subscriber or the Subscriber's spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption means the assumption and retention by a Subscriber or a Subscriber's spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated. The limiting age for Dependent children is 26, unless they have access to other health coverage through their employer or their spouse's employer. For such Dependent children, the limiting age is as stated in the Employer/Group Agreement	**15 Definitions** **Eligible Family Dependent** Eligible Family Dependent means: 1. The legally recognized Spouse or Domestic Partner of a Subscriber; 3. In relation to a Subscriber, the following individuals: f) A biological child, step-child, or legally adopted child; g) An unmarried grandchild for whom the Subscriber or the ~~Subscriber's~~ Spouse provides at least 50% support; h) A child placed for adoption with the Subscriber or ~~Subscriber's~~ Spouse; i) An unmarried individual for whom the Subscriber or ~~the Subscriber's~~ Spouse is a legal guardian and for whom the Subscriber or ~~the Subscriber's~~ Spouse provides at least 50% support; and j) A child whom the Subscriber or ~~the Subscriber's~~ Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption means the assumption and retention by a Subscriber or a ~~Subscriber's~~ Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated. The limiting age for Dependent children is 26 and such children shall become ineligible for coverage on the last day of the month in which their 26th birthday occurs. ~~, unless they have access to other health coverage through their employer or their~~	Administrative Change Benefit Change

Topic	Affected Materials	Description	Current Language & Provisions (from existing August 2012 documents)	New Language & Provisions (in new January 2014 documents)	Change Type
			and such children shall become ineligible for coverage on the last day of the month in which they attain the limiting age (e.g., their 26th birthday if the limiting age is 26). A covered Dependent child who becomes an Eligible Employee through the Employer is no longer an Eligible Family Dependent under the Group Contract. 3. An individual specified in subsection 2(a) or 2(d) of this definition if: a) The individual is older than the limiting age specified in the Employer/Group Agreement; and b) The individual became developmentally or physically disabled and incapable of self-sustaining employment prior to the limiting age. Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under the Group Contract, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age as stated in the Employer/Group Agreement. Thereafter, we may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to us, the individual's coverage will not continue beyond the last date of eligibility.	~~spouse's employer. For such Dependent children, the limiting age is as stated in the Employer/Group Agreement and such children shall become ineligible for coverage on the last day of the month in which they attain the limiting age (e.g., their 26th birthday if the limiting age is 26).~~ ~~A covered Dependent child who becomes an Eligible Employee through the Employer is no longer an Eligible Family Dependent under the Group Contract.~~ 3. An individual specified in subsection 2(a) or 2(d) of this definition if: The individual is older than the limiting age specified in the Employer/Group Agreement; ~~and~~ The individual became developmentally or physically disabled and incapable of self-sustaining employment prior to the limiting age; and The individual is unmarried. Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under the Group Contract, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age as stated in the Employer/Group Agreement. Thereafter, we may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to us, the individual's coverage will not continue beyond the last date of eligibility.	

APPENDIX 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)	$500 per person $1,000 per family (2 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.
- 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 deductible(s) are included in the Out-of-Pocket Maximum amount(s) listed above.
- 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 ✓ No deductible needs to be met prior to receiving this service	After you pay your calendar year deductible, then you pay the following for covered services Copay or Coinsurance (from participating providers only)
Physician / Provider Services	
• Office visits	$20 / visit✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓
• Office visits to alternative care providers	$20 / visit✓
• 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	$20 / visit✓
• 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	Covered in full✓
• High-tech 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, deductible waived)	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)	$20 / visit✓
• Emergency medical transportation	20%

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Other Covered Services	
• Colonoscopy, sigmoidoscopy	Covered in full✓
• Outpatient rehabilitative services *(limited to 30 visits per calendar year)*	$20 / visit✓
• 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, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)	
• Inpatient and day treatment services	20%
• Residential services	20%
• Outpatient provider visits	$20 / visit✓

Your guide to the words or phrases used to explain your benefits

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.

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.

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.

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
Spinal Manipulation, Acupuncture and Massage Therapy

Clackamas County - General County Employees on a Personal Option Plan

PROVIDENCE Health Plan

Copay
$20

Maximum Calendar Year Benefit
$1,500 per member

Important information about your plan

These benefits are 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.

- With this benefit you have access to participating chiropractors, acupuncturists and massage therapists for spinal manipulation, acupuncture, and massage therapy.
- 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 benefits

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

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

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 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.

Spinal 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.

Your guide to the words or phrases used to explain your benefits

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.

Your Benefit Summary

Open Option Plan

Clackamas County - General County Employees

PROVIDENCE Health Plan

Copay	What You Pay In-Plan	What You Pay Out-of-Plan	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)	$500 per person $1,000 per family (2 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.
- Your deductible(s) are included in the Out-of-Pocket Maximum amount(s) listed above.
- 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).
- 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	$15 / visit✓	30%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	30%✓
• Office visits to alternative care providers	$15 / visit✓	30%
• Vision and hearing screenings for children under 18	Covered in full✓	30%✓
• Routine immunizations; shots	Covered in full✓	30%✓
• Maternity services: prenatal	Covered in full✓	30%
• Maternity services: delivery and postnatal	$150 / delivery✓	30%
• Allergy shots; serums; injectable medications	10%	30%
• Inpatient hospital visits	10%	30%
• Surgery; anesthesia	10%	30%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	30%✓
• Mammograms	Covered in full✓	30%
Hospital Services		
• Inpatient care	10%	30%
• Observation care	10%	30%
• Maternity care	10%	30%
• Routine newborn nursery care	10%✓	30%
• Rehabilitative care (30 days per calendar year)	10%	30%
• Skilled nursing facility (60 days per calendar year)	10%	30%
Outpatient Diagnostic Services		
• X-ray; lab services	10%✓	30%
• High-tech imaging services (such as PET, CT, MRI)	10%✓	30%
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)	10%✓	30%
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)	$15 / visit✓	30%✓
• Emergency medical transportation	10%	10%

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services		
• Colonoscopy, sigmoidoscopy	Covered in full✓	30%
• Outpatient rehabilitative services (30 visits per calendar year)	10%	30%
• 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
• Home health care	10%	30%
• 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	$50✓	Not covered
-Non-formulary brand-name drugs	$100✓	Not covered
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	10%	30%
• Residential services	10%	30%
• Outpatient provider visits	$15 / visit✓	30%✓

Your guide to the words or phrases used to explain your benefits

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 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-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.

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
Spinal Manipulation, Acupuncture and Massage Therapy
Clackamas County - General County Employees on an Open Option Plan

PROVIDENCE Health Plan

Copay
$15

Maximum Calendar Year Benefit
$1,500 per member

Important information about your plan
These benefits are 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.

- With this benefit you have access to participating chiropractors, acupuncturists and massage therapists for spinal manipulation, acupuncture, and massage therapy.
- 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 benefits
This plan covers spinal manipulations, acupuncture and massage therapy when they are:

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

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 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.

Spinal 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.

Your guide to the words or phrases used to explain your benefits

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.

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

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, including your Member Handbook, register for myProvidence at www.ProvidenceHealthPlan.com/getstarted.

- 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.

Your guide to the words or phrases used to explain your benefits

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.

Your Benefit Summary
Vision Premium Plan

PROVIDENCE Health Plan

Benefits

Your Providence Health Plan vision benefit provides coverage as follows:
Comprehensive WellVision Exam®

- Adults: covered after $10 copay, once every 12 months
- Children (up to 19): covered in full every 12 months

Hardware

- Adults: benefits available every 12 months
  Lenses: one pair of lenses; single vision, lined bifocal, lined trifocal, lenticular
  Frames: one frame covered up to $130
  Elective contact lenses in lieu of glasses: covered up to $130, available every 12 months
- Children (up to 19): benefits are covered in full once every 12 months
  Frames: one frame from the Pediatric Exchange Collection
  Lenses: one pair; single vision, lined bifocal, lined trifocal, lenticular
  Elective contact lenses: in lieu of glasses, covered up to limits:
    Standard (one pair) - 1 contact lens per eye (total 2 lenses)
    Monthly (six-month supply) - 6 lenses per eye (total 12 lenses)
    Bi-weekly (3 month supply) - 6 lenses per eye (total 12 lenses)
    Dailies (one month supply) - 30 lenses per eye (total 60 lenses)

Using your vision plan benefit

- While you don't need a physician's referral to see a vision provider, generally your out-of-pocket costs will be less when you see a participating provider. To find a participating provider in your area, go to www.ProvidenceHealthPlan.com or call VSP at 800-877-7195.
- Be sure you present your current Providence Health Plan member identification card, along with your copayment.

Important information about your vision plan

- With this benefit you have access to over 50,000 participating providers located in retail, neighborhood, medical and professional settings.
- You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your vision care benefit.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits.

Using non-participating providers

- Generally your out-of-pocket costs will be less when you see a participating provider. To find a participating provider in your area, visit us online or call 800-877-7195.
- If you choose to use a non-participating provider the following dollar limits apply to your benefits:
  Routine vision exam: after your copay, covered up to $45
  Lenses:
    Single vision: covered up to $30
    Bifocal: covered up to $50
    Trifocal: covered up to $70
  Frames: covered up to $70
  Elective contact lenses (in lieu of glasses): covered up to $105

Discounts available with VSP Preferred providers

- 20% off complete pairs of prescription glasses
- 20% off all lens options
- 20% off unlimited non-prescription sunglasses
- 15% off contact lens exam, excluding materials

Discounts valid through any VSP Preferred Provider within 12 months of the last covered eye exam.

Exclusions

- Orthoptic or vision training
- Subnormal vision aids, aneseikonic lenses, or Plano (non-prescription lenses) glasses
- Sunglasses
- All materials not listed as covered benefits
- Services and supplies received outside of the United States
- Sport goggles or safety glasses
- Medical or surgical treatment
- Supplemental testing

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; pre- and postnatal visits	$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, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)	
• Inpatient and day treatment services	Covered in full
• Residential services	Covered in full
• Outpatient provider visits	$15 / visit

Your guide to the words or phrases used to explain your benefits

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.

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

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: pre- and postnatal visits	$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, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	Covered in full	20%
• Residential services	Covered in full	20%
• Outpatient provider visits	$10 / visit✓	20%✓

Your guide to the words or phrases used to explain your benefits

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.

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, including your Member Handbook, register for myProvidence at www.ProvidenceHealthPlan.com/getstarted.

- 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, coinsurance 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.
- 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.

Your guide to the words or phrases used to explain your benefits

Brand-name drug
Brand name drugs are protected by U.S. patent laws for up to 20 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.

Your Benefit Summary
Vision Basic Plan

PROVIDENCE Health Plan

Benefits
Your Providence Health Plan vision benefit provides coverage as follows:
Comprehensive WellVision Exam®

- Adults: covered after $10 copay, once every 12 months
- Children (up to 19): covered in full every 12 months

Hardware

- Adults: benefits available every 24 months
  Lenses: one pair of lenses; single vision, lined bifocal, lined trifocal, lenticular
  Frames: one frame covered up to $130
  Elective contact lenses in lieu of glasses: covered up to $130
- Children (up to 19): benefits are covered in full once every 12 months
  Lenses: one pair; single vision, lined bifocal, lined trifocal, lenticular
  Frames: one frame from the Pediatric Exchange Collection
  Elective contact lenses: in lieu of glasses, covered up to limits:
    Standard (one pair) - 1 contact lens per eye (total 2 lenses)
    Monthly (six-month supply) - 6 lenses per eye (total 12 lenses)
    Bi-weekly (3 month supply) - 6 lenses per eye (total 12 lenses)
    Dailies (one month supply) - 30 lenses per eye (total 60 lenses)

Using your vision plan benefit

- While you don't need a physician's referral to see a vision provider, generally your out-of-pocket costs will be less when you see a participating provider. To find a participating provider in your area, go to www.ProvidenceHealthPlan.com or call VSP at 800-877-7195.
- Be sure you present your current Providence Health Plan member identification card, along with your copayment.

Important information about your vision plan

- With this benefit you have access to over 50,000 participating providers located in retail, neighborhood, medical and professional settings.
- You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your vision care benefit.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits.

Using non-participating providers

- Generally your out-of-pocket costs will be less when you see a participating provider. To find a participating provider in your area, visit us online or call 800-877-7195.
- If you choose to use a non-participating provider the following dollar limits apply to your benefits:
  Routine vision exam: after your copay, covered up to $45
  Lenses:
    Single vision: covered up to $30
    Bifocal: covered up to $50
    Trifocal: covered up to $70
  Frames: covered up to $70
  Elective contact lenses (in lieu of glasses): covered up to $105

Discounts valid through any VSP Preferred Provider within 12 months of the last covered eye exam.

Discounts available with VSP Preferred providers

20% off complete pairs of prescription glasses

20% off all lens options

20% off unlimited non-prescription sunglasses

15% off contact lens exam, excluding materials

Exclusions

- All materials not listed as covered benefits
- Sport goggles or safety glasses
- Subnormal vision aids, aneseikonic lenses, or Plano (non-prescription lenses) glasses
- Sunglasses
- Orthoptic or vision training
- Supplemental testing
- Medical or surgical treatment
- Services and supplies received outside of the United States

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.

Your guide to the words or phrases used to explain your benefits

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.

APPENDIX 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 14C - Custom subgroups 001, etc.

Region: Northwest
Contract Period: 01/01/2014 - 12/31/2014
Report Period: Apr 2012 through Mar 2013

		Apr12-Mar13
Average Members:		1,442
Rating Month:	April 2013	
Rating Members:	1,264	

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,686,532	$386.505
A2	- Pooling Credit	Pooling Point:$160,000			($0.568)	(2.923)
A3	- Pooling Charge				167,637	9.690
A4	Claims Net of Pooling				$6,803,601	$393.272
A5	X Incurred Claims Adjustment			1.01645		
A6	X Demographic Change			0.99762		
A7	X Historical Benefit Change			1.002850		
A8	Adjusted Claims					$399.925
A9	X Trend Factor	Annual Trend: 6.73%		1.12069		
A10	Claims based PMPM	21.0 Months Midpoint to Midpoint				$448.192
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$566,515	$448.192
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$566,515	$448.192
D4	+ Retention		40,815	32.290
D5	+ Other Benefits		15,610	12.350
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		2,053	1.624
D8	+ Federal Health Insurer Fee		4,133	3.270
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		6,851	5.420
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$635,977**	**$503.146**
E	**Capping**	**Increase**		
E1	In-Force Rate		$583,491	$461.623
E2	Premium Requirement without Benefit Change and Underwriter Adj	8.97%	635,812	503.016
E3	Capping Rate	9.05%	636,298	503.400
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**9.08%**	**636,462**	**503.530**
E5	X Underwriter Adjustment	0.99000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**7.99%**	**630,098**	**498.495**
E7	Capping Adjustment		485	0.384

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 14B - Custom subgroups 007, 018, 030

Region: Northwest
Contract Period: 01/01/2014 - 12/31/2014
Report Period: Apr 2012 through Mar 2013

	Apr12-Mar13
Average Members:	1,442
Rating Month:	April 2013
Rating Members:	236

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,686,532	$386.505
A2	- Pooling Credit	Pooling Point:$160,000			(50,568)	(2.923)
A3	+ Pooling Charge				167,637	9.690
A4	Claims Net of Pooling				$6,803,601	$393.272
A5	X Incurred Claims Adjustment			1.01645		
A6	X Demographic Change			0.99762		
A7	X Historical Benefit Change			1.000140		
A8	Adjusted Claims					$398.848
A9	X Trend Factor	Annual Trend: 6.73%		1.12069		
A10	Claims based PMPM	21.0 Months Midpoint to Midpoint				$446.985
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$105,488	$446.985
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$105,488	$446.985
D4	+ Retention		7,620	32.290
D5	+ Other Benefits		2,761	11.700
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		382	1.618
D8	+ Federal Health Insurer Fee		769	3.258
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		1,279	5.420
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$118,300**	**$501.271**
E	**Capping**	**Increase**		
E1	In-Force Rate		$106,794	$452.519
E2	Premium Requirement without Benefit Change and Underwriter Adj	10.71%	118,236	501.001
E3	Capping Rate	9.05%	116,459	493.472
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**9.11%**	**116,523**	**493.742**
E5	X Underwriter Adjustment	0.99000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**8.02%**	**115,358**	**488.805**
E7	Capping Adjustment		(1,777)	(7.529)

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 1000 – Custom subgroups 058, 060

Region: Northwest
Contract Period: 01/01/2014 – 12/31/2014
Report Period: Apr 2012 through Mar 2013

	Apr12-Mar13
Average Members:	1,442

Rating Month: April 2013
Rating Members: 5

Medical Calculation

			Weight	Factor	Totals	PMPMS
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,686,532	$386.505
A2	– Pooling Credit	Pooling Point:$160,000			(50,568)	(2.923)
A3	+ Pooling Charge				167,637	9.690
A4	Claims Net of Pooling				$6,803,601	$393.272
A5	X Incurred Claims Adjustment			1.01645		
A6	X Demographic Change			0.99762		
A7	X Historical Benefit Change			0.750570		
A8	Adjusted Claims					$299.320
A9	X Trend Factor	Annual Trend: 6.73%		1.12069		
A10	Claims based PMPM	21.0 Months Midpoint to Midpoint				$335.445
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPMS
D	**Total Rate Calculation**			
D1	Blended Rate		$1,677	$335.445
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$1,677	$335.445
D4	+ Retention		161	32.290
D5	+ Other Benefits		59	11.700
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		6	1.254
D8	+ Federal Health Insurer Fee		13	2.526
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		27	5.420
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$1,943**	**$388.635**
E	**Capping**	**Increase**		
E1	In-Force Rate		$2,198	$439.696
E2	Premium Requirement without Benefit Change and Underwriter Adj	(11.67)%	1,942	388.365
E3	Capping Rate	9.05%	2,397	479.488
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**9.11%**	**2,399**	**479.758**
E5	X Underwriter Adjustment	0.99000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**8.02%**	**2,375**	**474.960**
E7	Capping Adjustment		456	91.123

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 1000 - Custom subgroups 059, 063*

Region: Northwest
Contract Period: 01/01/2014 - 12/31/2014
Report Period: Apr 2012 through Mar 2013

	Apr12-Mar13
Average Members:	1,442
Rating Month:	April 2013
Rating Members:	8

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$6,686,532	$386.505
A2	- Pooling Credit	Pooling Point:$160,000			(50,568)	(2.923)
A3	+ Pooling Charge				167,637	9.690
A4	Claims Net of Pooling				$6,803,601	$393.272
A5	X Incurred Claims Adjustment			1.01645		
A6	X Demographic Change			0.99762		
A7	X Historical Benefit Change			0.752600		
A8	Adjusted Claims					$300.128
A9	X Trend Factor	Annual Trend: 6.73%		1.12069		
A10	Claims based PMPM	21.0 Months Midpoint to Midpoint				$336.351
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$2,691	$336.351
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$2,691	$336.351
D4	+ Retention		258	32.290
D5	+ Other Benefits		94	11.700
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		10	1.257
D8	+ Federal Health Insurer Fee		20	2.532
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		43	5.420
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**Uncapped PMPM Premium Requirement**		**$3,116**	**$389.550**
E	**Capping**	**Increase**		
E1	In-Force Rate		$3,517	$439.640
E2	Premium Requirement without Benefit Change and Underwriter Adj	(11.46)%	3,114	389.280
E3	Capping Rate	9.05%	3,835	479.427
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**9.11%**	**3,838**	**479.697**
E5	X Underwriter Adjustment	0.99000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**8.02%**	**3,799**	**474.900**
E7	Capping Adjustment		721	90.147

APPENDIX E

Kaiser Permanente 2014 Contract Changes

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2014 *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," riders, and any applicable endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement* and any changes we have made at your Group's request. 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 benefits shown on the rate and benefit summary pages in the Group's renewal packet 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 2014. 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

- The "What You Pay" *EOC* section has been modified. For Deductible and Added Choice Plans, the Deductible now counts toward the Out-of-Pocket Maximum, in addition to Copayments and Coinsurance. However, prescription drug benefits, self-referred alternative care, adult hearing aids, and vision hardware provided under a separate benefit rider do not accumulate to the Out-of-Pocket Maximum on these plans. This change applies to nongrandfathered plans only.
- The hearing aid annual allowance for the state-mandated hearing aid benefit for Members age 18 and younger and for enrollees age 19 and older who are under the Dependent Limiting Age and enrolled in an accredited education institution has changed from a dollar allowance to a frequency limit of one hearing aid per ear every four years. For Added Choice medical plans, the dollar allowance still applies when hearing aids are dispensed by a Non-Participating Vendor, but the allowance has been increased based on the Consumer Price Index for medical care.

Benefit clarifications

- The definition of "Essential Health Benefits" has been added to the *EOC* "Definitions" section. Essential Health Benefits are not subject to any lifetime benefit maximum amounts or annual dollar limits in accordance with the Affordable Care Act (ACA).
- The reference to pap smear test in the "Preventive Care Services" and "Women's Health Services" *EOC* provisions has been changed to cervical cancer screening to more accurately describe the preventive screening.

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- Colorectal cancer screenings have been added to the bullet list of covered Services in the "Preventive Care Services" *EOC* provision for clarification.
- Contraceptive services and supplies have been added to the bullet list of covered Services in the "Preventive Care Services" *EOC* provision for clarification.
- Cardiac rehabilitative therapy visits have been added to the bullet list of covered Services in the "Benefits for Outpatient Services" *EOC* provision for clarification.
- Internally implanted devices have been added to the bullet list of covered Services under both "Benefits for Outpatient Services" and "Benefits for Inpatient Hospital Services" provisions in the "Benefits" *EOC* section for clarification.
- The "Health Education Services" provision in the "Benefits" *EOC* section has been modified. We have added tobacco use cessation under the bulleted list of Services. We have also explained that some Services may be subject to any applicable Deductible, Coinsurance, Copayments, or fees associated with heath education classes.
- A "Limited Dental Services" provision has been added to the "Benefits" *EOC* section to provide a more detailed explanation of dental-related covered Services.
- The "Limited Outpatient Prescription Drugs, Supplies, and Supplements" *EOC* section has been modified. Post-surgical immunosuppressive drugs after covered transplant Services have been added to the bulleted list of covered drugs for clarification.
- Preventive medications (such as aspirin, fluoride, and iron), when obtained with a prescription order and recommended by the U.S. Preventive Services Task Force, have been added to the bullet list of covered drugs in the "Limited Outpatient Prescription Drugs, Supplies, and Supplements" *EOC* provision for clarification.
- The "Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices" *EOC* section has been modified. The benefits are now described in two sections for clarity: "Outpatient Durable Medical Equipment (DME)" and a separate "External Prosthetic Devices and Orthotic Devices" section. In addition, we have removed the age restriction for ocular prosthesis coverage.
- A "Services Provided in Connection with Clinical Trials" provision has been added to the "Benefits" *EOC* section to provide a more detailed explanation of coverage.
- A "Telemedical Services" provision has been added to the "Benefits" *EOC* section in accordance with state requirements.
- For all medical plans that include a Deductible, we have reformatted the *EOC* "Benefit Summary" by moving the Deductible row above the Out-of-Pocket Maximum row for consistent placement.

Administrative changes or clarifications

- The "Termination for Discontinuance of Plan or all Plans within a Market" section of the *Group Agreement* has been modified for nongrandfathered groups. The reference in the first sentence to "small or large" group market has been deleted and replaced with "the group market." The same change has been made in the "Termination of Certain Types of Health Benefit Plans by Us" provision in the "Termination of Membership" *EOC* section. The language has been changed to more closely align with Health and Human Services (HHS) proposed regulations.
- The "Dependents" provision in the "Who Is Eligible" *EOC* section has been modified. We have removed the language that proof incapacity and dependency be provided after the two-year period following

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attainment of the general Dependent Limiting Age. We have clarified that we may request proof of incapacity and dependency annually to match our administration.

- The "Adding New Dependents to an Existing Account" provision in the "When You Can Enroll and When Coverage Begins" *EOC* section has been modified. Enrollment applications for newborns or newly adopted children are due to the Group within 31 days after birth or adoption. Previously, applications were due within 60 days.
- An "Other Special Enrollment Events" provision has been added to the "When You Can Enroll and When Coverage Begins" *EOC* section to comply with the guaranteed availability provisions of the ACA.
- The "Mental Health Services" provision of the "Benefits" *EOC* section has been modified. We have added a statement confirming that the benefits described comply with the federal Mental Health Parity and Addiction Equity Act.
- The "Continuation of Group Coverage under the Consolidated Budget Reconciliation Act (COBRA)" provision in the "Continuation of Membership" *EOC* section has been modified. The reference to "federally recognized religious organizations" has been changed to "church plans as defined by federal law" in accordance with federal law.
- The "Grievances, Claims, Appeals, and External Review" *EOC* section has been changed for consistency with our administration.
- We have deleted references to portability coverage in the "Continuation of Coverage" *EOC* section. Portability coverage will no longer be offered in Oregon due to the availability of coverage from the state's health insurance exchange.
- The "Termination for Cause" provision of the "Termination of Membership" *EOC* section has been modified. We have deleted the bullet that states we may terminate your membership with 31 days' notice for abusing or threatening the safety of Company employees or of any person or property at Participating or Select Facilities.
- The "Nondiscrimination" provision of the "Miscellaneous Provisions" *EOC* section has been updated in accordance with the ACA.

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

Benefit changes

- The "What You Pay" *EOC* section has been modified. For three-tier plans, Deductible and Out-of-Pocket Maximum amounts cross accumulate between Tiers 1 and 2. There is a separate Deductible and Out-of-Pocket Maximum amount in Tier 3, which does not accumulate across any other tiers.

Benefit clarifications

- The "What You Pay" *EOC* section has been edited for clarity and to remove redundant language.
- We have deleted the row for neurodevelopmental therapy from the *EOC* "Benefit Summary" to avoid confusion. The benefit may be covered under physical therapy, occupational therapy, or speech therapy Services.

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Changes and clarifications that apply to medical benefit riders

Benefit changes

- Pediatric vision hardware covered under the "Pediatric Vision Hardware and Optical Services Rider" has changed from a dollar allowance to a frequency limit.

Benefit clarifications

- The "Alternative Care Services Rider" has been modified. We have clarified the exclusions and also have moved the "Alternative Care Services Benefit Summary" to the end of the rider.
- The "Chiropractic Services Rider" has been modified. We have clarified the exclusions and also have moved the "Chiropractic Services Benefit Summary" to the end of the rider.
- The "Expanded Choice Rider" has been modified. We have updated the definition of Participating Vendor.
- The "Outpatient Prescription Drug Rider" available for Deductible or High Deductible Health Plans has been modified. Language has been added to the formulary contraceptive row in the "Outpatient Prescription Drug Rider Benefit Summary" to clarify that coverage is not subject to any Deductible.
- The "Outpatient Prescription Drug Rider" has been modified. Language has been added regarding day supply limits to the formulary contraceptive row in the "Outpatient Prescription Drug Rider Benefit Summary" for consistency.
- The "Outpatient Prescription Drug Rider" that includes Specialty Drugs has been modified. Language has been added regarding day-supply limits to the Specialty Drug row in the "Outpatient Prescription Drug Rider Benefit Summary" for consistency.
- The Added Choice "Outpatient Prescription Drug Rider" that includes the MedImpact pharmacy network option has been modified. For ease of reference, we have split out the "Outpatient Prescription Drug Rider Benefit Summary" into two separate tables: one for Select pharmacies and one for MedImpact pharmacies.

Changes and clarifications that apply to dental plans

Benefit changes

- In the Dental Choice PPO Plan, the 12-month exclusion for Services related to replacement of a missing natural tooth, lost prior to the Member's effective date, has been removed from the "Exclusions and Limitations" *EOC* section.

Benefit clarifications

- In the Dental Choice PPO Plan, the exclusion for restorative or reconstructive treatment for specific congenital or developmental malformations has been removed as redundant. All dental Services are covered up to the benefit level of the least costly treatment alternative, as explained in the "Benefits" section.
- The Dental Choice PPO Plan "Benefit Summary" has been redesigned for ease of reference. The "In-network benefit" and "Out-of-network benefit" values are now listed in two separate columns.

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- The benefit for nitrous oxide under the "Other Benefits" provision in the "Benefits" *EOC* section has been modified. We have removed the language that stated the benefit must be administered by a pediatric dentist, oral surgeon, or periodontist.

Administrative changes or clarifications

- The "Continuation of Group Coverage under the Consolidated Budget Reconciliation Act (COBRA)" provision in the "Continuation of Membership" *EOC* section has been modified. Language has been added explaining that COBRA does not apply to church plans as defined by federal law.
- The "Coordination of Benefits" provision in the "Reductions" *EOC* section was modified. Some minor wording changes were made to correct "medical" references to "dental."

Changes and clarifications that apply to all Senior Advantage plans

The following changes take effect as Groups renew in 2014 unless otherwise noted.

Benefit changes

- Partial hospitalization services cost-share has been changed to the primary care visit copayment. Previously, the Member cost-share was half the inpatient hospitalization cost-share or $110 per day per admit, whichever was less.
- Prescription medication cost-share has been changed for two categories of Medicare Part B prescription drugs: (1) clotting factors the Member would self-administer for treatment of hemophilia, and (2) immunosuppressive drugs if the Member was enrolled in Medicare Part A at the time of their organ transplant. For generic drugs, Members pay the same copayment as they would pay for Part D covered non-preferred generics. For brand drugs, Members pay the same copayment as they would pay for Part D covered preferred brands. Previously, these drugs were covered at no charge.

Administrative changes or clarifications

- The Senior Advantage enrollment form has been updated. The new form is required for all enrollments effective on or after January 1, 2014. The new form is available from your account manager starting October 1, 2013. Please note that Senior Advantage enrollments submitted using the prior form will be sent back to the Member and will not be processed until the new form is submitted.
- The "Medicare as Primary Payer" section of the *Group Agreement* has been modified. We charge the non-Medicare Premium for Medicare primary members who are entitled to Medicare benefits due to disability, end-stage renal disease, COBRA, and domestic partner status, and who are not enrolled in Kaiser Permanente Senior Advantage.

APPENDIX 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 C14C
January 1, 2014 through December 31, 2014

Out-of-Pocket Maximum (*All 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
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$10
Specialty care visit	$10
Urgent care visit	$10
Emergency department visit	$75 (Waived if admitted)
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Laboratory, X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Routine eye exam	$10
Nurse treatment room visits to receive injections	$0
Administered medications, including injections (all outpatient settings)	$0
Outpatient 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
Inpatient Hospital Services	$0
Ambulance Services (per transport)	$75
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees ages 19 to 25 and enrolled in an accredited educational institution)	$0
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
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

Optional Benefits (Amounts do not count toward the maximum.)	
Alternative care (self-referred)	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing aids (ages 19 years and older)	Balance after $1,500 allowance is applied for each hearing aid per ear every three years
Outpatient prescription drugs	$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.
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

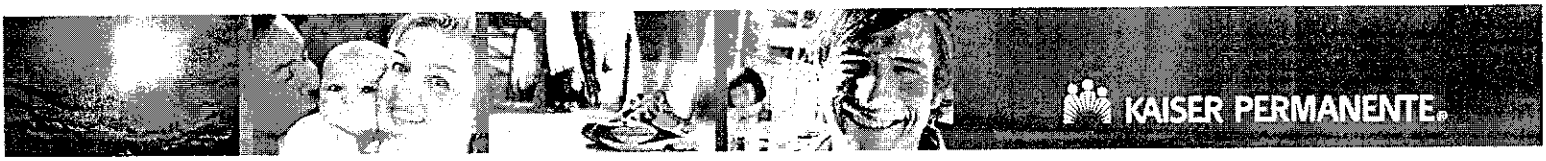
Exclusions and Limitations

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)*.

Acupuncture. Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) the Alternative Care (self-referred Acupuncture Services) rider has been purchased.; **Certain exams and Services; Chiropractic Services received without a referral.** Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care Services or Chiropractic Services (self-referred Chiropractic Care) rider has been purchased.; **Cosmetic Services; Custodial Services; Dental Services.** Except when Medically Necessary for Members who have a medical condition that would place undue risk if performed in a dental office. The procedure is subject to Utilization Review.; **Designated blood donations; Detained or confined members; Employer responsibility; Experimental or investigational Services; Eye surgery.** Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.; **Family Services.** Services provided by a member of your immediate family.; **Genetic testing; Government agency responsibility; Hearing aids.** Unless the Hearing Aid rider has been purchased.; **Hypnotherapy; Intermediate Services; Massage therapy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care (Massage Therapy) rider has been purchased.; **Naturopathy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria; or (b) Alternative Care (Naturopathy Services) rider has been purchased.; **Non-Medically Necessary Services; Nonreusable medical supplies; Outpatient Prescription Drugs.** Unless the Outpatient Prescripuon Drug rider has been purchased. Our drug formulary applies. We cover non-formulary drugs only when you meet exception criteria unless specifically covered by your prescription drug plan.; **Professional Services for fitting and follow-up Services for contact lenses; Services performed by unlicensed people; Services related to a non-covered Service; Services that are not health care Services, supplies, or items; Supportive care and other Services; Travel and lodging.** Limited to: (a) Medically Necessary ambulance Services, and (b) certain expenses that we preauthorize.; **Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless the Travel Services rider has been purchased.; **Vision hardware and optical Services (ages 18 and younger).** Unless the Pediatric Vision Hardware and Optical Services rider has been purchased.; **Vision hardware and optical Services (ages 19 and older).** Unless the Adult Vision Hardware and Optical Services rider has been purchased.; **Vision therapy and orthoptics or eye exercises.**

Questions? Call Membership Services (M-F, 8 am-6 pm) or visit **kp.org**
Portland area..503-813-2000. All other areas..1-800-813-2000. TTY..1-800-735-2900.
Language Interpretation Services, all areas..1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your *EOC* or call Membership Services. In the case of conflict between this summary and the *EOC*, the *EOC* will prevail.



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 (POA)
Oregon Traditional Copayment Plan C14B
January 1, 2014 through December 31, 2014

Out-of-Pocket Maximum (All 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
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$10
Specialty care visit	$10
Urgent care visit	$10
Emergency department visit	$75 (Waived if admitted)
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Laboratory, X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Routine eye exam	$10
Nurse treatment room visits to receive injections	$0
Administered medications, including injections (all outpatient settings)	$0
Outpatient 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
Inpatient Hospital Services	$0
Ambulance Services (per transport)	$75
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees ages 19 to 25 and enrolled in an accredited educational institution)	$0
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
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

Optional Benefits (Amounts do not count toward the maximum.)	
Alternative care (self-referred)	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing aids (ages 19 years and older)	Not covered
Outpatient prescription drugs	$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.
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

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 Membership Services (M-F, 8 am-6 pm) or visit **kp.org**
Portland area..503-813-2000. All other areas..1-800-813-2000. TTY..1-800-735-2900.
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 -- General County Early Retirees
Oregon Deductible Plan 3C14
January 1, 2014 through December 31, 2014

Deductible	
For one Member	$1,000 per Calendar Year
For an entire Family	$3,000 per Calendar Year
Out-of-Pocket Maximum (All Deductible, 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
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$25
Specialty care visit	20% Coinsurance after Deductible
Urgent care visit	$25
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Laboratory, X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0
Routine eye exam	$25
Nurse treatment room visits to receive injections	$5
Administered medications, including injections (all outpatient settings)	$0
Outpatient 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
Inpatient Hospital Services	20% Coinsurance after Deductible
Ambulance Services (per transport)	20% Coinsurance after Deductible
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees ages 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance after Deductible
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
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
Optional Benefits (Amounts do not count toward the maximum.)	
Alternative care (self-referred)	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing aids (ages 19 years and older)	Balance after $1,500 allowance is applied for each hearing aid per ear every three years
Outpatient prescription drugs	$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.
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

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of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

Clackamas County 1183 – Peace Officers Early Retirees
Oregon Deductible Plan 3C14
January 1, 2014 through December 31, 2014

Deductible	
For one Member	$1,000 per Calendar Year
For an entire Family	$3,000 per Calendar Year
Out-of-Pocket Maximum (All Deductible, 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
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$25
Specialty care visit	20% Coinsurance after Deductible
Urgent care visit	$25
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Laboratory, X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0
Routine eye exam	$25
Nurse treatment room visits to receive injections	$5
Administered medications, including injections (all outpatient settings)	$0
Outpatient 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
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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
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
Optional Benefits (Amounts do not count toward the maximum.)	
Alternative care (self-referred)	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing aids (ages 19 years and older)	Not covered
Outpatient prescription drugs	$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.
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.
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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 dental benefits

Clackamas County 1183-043
Oregon Dental Plan C
January 1, 2014 through December 31, 2014

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 or Benefit Maximum)	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

- 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.
- 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.
- Sedation and general anesthesia are not covered, except nitrous oxide.
- Works-in-Progress started prior to effective date of coverage.

Questions? Call Membership Services (M-F, 8 am-6 pm) or visit **kp.org/dental/nw**
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Language Interpretation Services, all areas..1-800-324-8010

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APPENDIX G

Moda 2014 Contract Changes

moda HEALTH

Clackamas County - 10000174

ASO Dental Plan Changes

Effective January 1, 2014

The following is a summary of the significant changes that will be made to the ODS member handbook effective January 1, 2014. Additional regulatory changes may be required at any time as a result of new federal rules or regulations or changes to existing PPACA rules or regulations. ODS will provide written notice of any additional changes required by law, and will administer such changes accordingly. The summary is provided for your convenience and shall not be binding upon the parties. The language in the member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic, or formatting changes, are not included in this summary.

REGULATORY CHANGES		
Continuation of Dental Coverage – Individual Dental Exchange Program	The Individual Dental Exchange Program has been discontinued. ODS offers competitive individual dental plans in lieu of the Individual Dental Exchange Program.	Individual Dental Exchange Program was for members who had been covered for 12 months under an employer sponsored dental program.

BENEFIT CHANGES					
Accepted		**Reference**	**Change/Rationale/Exceptions**	**Former Benefit**	**Claims Impact**
Yes	**No**				
☒	☐	Throughout handbook (for groups that cover Oregon registered domestic partners)	include coverage for domestic partners under any legal registry in the United States, due to the increase in US registries	Domestic partners registered in Oregon were covered.	negligible
☐	☒	**Benefits and Limitations –** Implants	Cover the final implant-supported bridge retainer and implant abutment or pontic once per tooth or tooth space over the lifetime of the implant.	Covered every 5 years.	Negligible
☒	☐	**Eligibility**	Add coverage for foster children to the list of eligible dependents. Under the Affordable Care Act, the definition of eligible dependents for minimum essential health care coverage includes certain foster children. *Offered as a option for* groups that want to match dependents covered under their medical plan.	Foster children were not covered.	Negligible

ADMINISTRATIVE CHANGES	
Reference	**Change/Rationale/Exceptions**
Definitions --	Combined definitions for Maximum Plan Allowance and Accepted Fee under the definition of Maximum Plan Allowance and added "When using a non-participating dentist or dental care provider, any amount above the MPA is the member's responsibility" for clarification.
Definitions	Removed definitions for Enrollment Date as it is not used in the handbook. Deleted Group Eligibility Period as it is redundant to the definition of Waiting Period. Removed Maximum Payment Limit as it is described in the Benefits and Limitations section.
Definitions – Cast Restorations	Added Cast Restorations that are made in a dental office are covered. Clarification
Definitions – Claim Determination Period	Moved Claim Determination period to Benefits and Limitations. Simplification.
Definitions – Cost Sharing Throughout handbook	Added definition for Cost Sharing. Replaced some deductible and coinsurance references throughout the handbook with cost sharing.
Definitions – Domestic Partners	Removed "same sex" from registered partners since this is implied for plans that allow registration through Oregon Family Fairness Act and not applicable for plans that include other state registries as some states register opposite sex domestic partners.
Definitions	Moved explanations of payment to a participating dentist to Benefits and Limitations.
Benefits and Limitations	Added payment is always limited to the Maximum Plan Allowance. Clarification.
Benefits and Limitations Throughout the section	Added "All "annual" or "per year" benefits or cost sharing accrue on a calendar (plan or eligibility if applicable) year basis and frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified. "Removed references to calendar (plan or eligibility if applicable).
Claims Administration & Payment Appeals	Removed internal policies and procedures from Adverse Benefit Determination Period. Removed the reference for right to file a lawsuit for ERISA plans from First Level Appeals as both levels of appeals must be completed prior to filing a lawsuit.
Continuation of Coverage	Removed references to pre-existing
Exhibits	Removed the example. Deleted Exhibit.

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.	+1%

APPENDIX H

Moda Benefit Summaries

ODS moda HEALTH

Dental Benefits Summary
Clackamas County
General County Incentive Dental Plan
Effective January 1, 2014

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

DELTA DENTAL

- **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
- **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

This product is administered
by Oregon Dental Service (ODS).
ODS is now part of the Moda Health organization.

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

This product is administered
by Oregon Dental Service (ODS).
ODS is now part of the Moda Health organization.

Dental Benefits Summary
Clackamas County
POA Incentive Dental Plan
Effective January 1, 2014

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

DELTA DENTAL

- **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
- **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.

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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.
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Dental Benefits Summary
Clackamas County
Constant Dental Plan
Effective January 1, 2014

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

DELTA DENTAL

- **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.
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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.
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Dental Benefits Summary
Clackamas County
Preventive Dental Plan
Effective January 1, 2014

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

DELTA DENTAL

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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.
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* Plaque control and oral hygience or dietary instructions.
* Experimental procedures.
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APPENDIX I

Self-funded Dental Plan Underwriting Calculation

Clackamas County

General County ODS Dental Plan Renewal Calculation

Effective: January 1, 2014

Experience Period: July 1, 2012 through June 30, 2013

Line No.		ODS Dental
	Base Period Experience	
1.	Average Monthly Enrollment	1,463
2.	Billed Premium	$2,345,764
3.	Paid Claims	2,072,403
	Basic Assumptions	
4.	Annual Trend	6.0%
5.	Reserve Factor	10.0%
6.	Margin	0.0%
	Premium (Includes ee contrib)	
7.	Adjusted Premium to 2013 Rates	$2,434,721
	Claims	
8.	Paid Claims: 7/12 through 6/13	$2,072,403
9.	Claims Adjustment for Benefit changes	0
10.	Adjusted Paid Claims	$2,072,403
11.	Beginning Reserve	(214,021)
12.	Ending Reserve	207,240
13.	Reserve Change	($6,781)
14.	Incurred Claims: 7/12 through 6/13	$2,065,622
	Projection	
15.	Annual Trend Factor	6.0%
16.	Extended Trend Factor for 18 mos.	1.091
17.	Projected Incurred Claims	$2,253,594
18.	Projected Incurred Loss Ratio	92.6%
19.	Margin	0.0%
20.	Projected Incurred Claims with Margin	$2,253,594
21.	Projected Incurred Loss Ratio with Margin	92.6%
	Expenses	
22.	Projected Renewal Administration expenses	
23.	Retention Net of Commission ($6.02 PEPM)	$105,669
24.	**Total Expenses**	$105,669
25.	Total Projected Outgo (Claims + Expenses)	$2,359,263
26.	**Needed Increase**	**-3.1%**
27.	**Total Cost (PEPM)**	**$134.41**

Mercer Health & Benefits LLC
111 SW Columbia Street, Suite 500
Portland, OR 97201-5839
+1 503 273 5900

Clackamas County

Flexible Benefits Program

Amended and Restated

Effective January 1, 2014

PREAMBLE

THIS CAFETERIA PLAN (hereinafter referred to as the "Program" and known as the Clackamas County Flexible Benefits Program) is amended and restated effective January 1, ~~2005~~2014, by Clackamas County (hereinafter "Employer").

WHEREAS, the Employer established this Program effective July 1, 1985, to enable Employees who become covered under the Program to elect payment of premiums for various coverages and reimbursement of certain expenses incurred by the Employee in lieu of cash compensation as provided herein; and

WHEREAS, with respect to benefit coverages, this Program concerns only Premium Expenses and has no effect on the benefits or claim payments made under each benefit coverage; and

WHEREAS, this Program contains certain definitions and general administrative provisions that govern the Program and each Component Plan, except to the extent a Component Plan may expressly provide otherwise; and

WHEREAS, the Employer last amended and restated the Program effective January 1, ~~2004~~2005; and,

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

WHEREAS, this Program is intended to qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (hereinafter "Code"), and comply with any other applicable law, including without limitation Sections 79, 105, 106, ~~and~~ 129 and 152 of the Code;

NOW, THEREFORE, the Employer does hereby amend and restate the Program as set forth in the following pages, effective January 1, ~~2005~~2014, except as otherwise specifically stated herein.

SECTION 1
DEFINITIONS

The following terms, when used herein, shall have the following meanings unless a different meaning is plainly required by the context. Capitalized terms are used throughout the text of the Program and each Component Plan for terms defined by this and other sections.

1.1 **ACA** means the Affordable Care Act of 2010 as amended and including all related regulations and other guidance.

~~1.1~~1.2 **Annual Electronic Enrollment ~~Form~~** means the ~~form~~ electronic enrollment options provided by the Employer for the purpose of allowing an Eligible Employee at the commencement of each Plan Year or upon becoming an Eligible Employee to participate in the Program by electing Salary Redirection and benefits described in Section 4.1, including various benefit coverages and reimbursements under a Component Plan, subject to the limitations stated herein.

~~1.2~~1.3 **COBRA Continuation Coverage** means continued health coverage which is available in certain situations where coverage would otherwise cease, in accordance with Sections 2201 to 2208 of the Public Health Service Act. For purposes of Section 4.3, "COBRA Continuation Coverage" includes coverage available under a similar state law.

~~1.3~~1.4 **Code** means the Internal Revenue Code of 1986, as amended, and including all related regulations.

~~1.4~~1.5 **Compensation** means, with respect to any pay period, the total cash remuneration received or that would have been received by the Participant from the Employer during the Coverage Period prior to any reductions pursuant to a Salary Redirection Agreement authorized under the Program.

~~1.5~~1.6 **Component Plan** means the Clackamas County Dependent Care Flexible Spending Account Plan, the Clackamas County Health Care Flexible Spending Account Plan, and

any other plan designated as a Component Plan that may be established from time to time by the Employer as part of the Program.

~~1.6~~1.7 **Coverage Period** means the Plan Year and any subsequent Grace Period, provided that:

(a) for any Employee who becomes an Eligible Employee after the start of a Plan Year, the initial Coverage Period shall mean the period commencing on the effective date of such Eligible Employee's participation in the Program and extending through the remainder of the Plan Year; and

(b) for any Employee who ceases to be an Eligible Employee before the end of a Plan Year, the final Coverage Period shall mean the period commencing on the later of: the first day of the Plan Year or the date the Employee becomes a Participant and extending through the date(s) participation terminates (with respect to each applicable benefit) pursuant to Section 2.3.

1.8 **Dependent** means any individual who satisfies the definition of a tax-qualified dependent under Section 152 of the Internal Revenue Code.

~~1.7~~1.9 **Domestic Partner** means an individual who satisfies the qualification requirements established by the Employer and with respect to whom a Participant completes an Affidavit of Domestic Partnership satisfactory to the Employer.

~~1.8~~1.10 **Effective Date** means July 1, 1985. The effective date of this amendment and restatement of the Program is January 1, ~~2005~~2014. The Effective Date for each Component Plan shall be the date stated in the Component Plan document.

~~1.9~~1.11 **Election Period** means the period immediately preceding each Coverage Period, which is designated by the Plan Administrator, provided, however, that the Election Period for an Eligible Employee who first becomes eligible to participate during a Coverage Period shall be as described in Section 2.

1.12 **Eligible Employee** means an Employee of the Employer in active pay status who is classified by the Employer as an elected official, a nonrepresented Employee, or an AFSCME-DTD, AFSCME-WES, AFSCME-C-COM, Employees' Association, or Housing

Authority Employees' Association employee, and who has completed two (2) months of continuous employment, and who is eligible to receive benefits pursuant to a group health, term life, or disability plan sponsored by the Employer that is a benefit option described in Section 4.1, except those individuals indicated below.

Effective on and after October 1, 1992, Employees classified as Federation of Parole and Probation Officers (FOPPO) Employees are Eligible Employees. Effective on and after January 1, 2002, Employees classified as Peace Officers Association (POA) Employees are Eligible Employees.

~~Each leave of absence where an Employee is in an unpaid status for more than ten (10) working days during the two (2) month waiting period delays the end of the waiting period one additional month.~~ Employees on an approved paid leave of absence or an unpaid FMLA leave who were Eligible Employees when such leave commenced continue to be Eligible Employees during the period of leave. Employees on an approved unpaid leave of absence continue to be Eligible Employees if continuation of coverage is required under the provisions of ACA.

The term "Eligible Employee" does not include independent contractors, nonresident aliens, leased Employees, or Employees covered by a collective bargaining agreement where welfare plan benefits were the subject of good faith bargaining and that does not provide for participation in this Program.

~~1.10~~1.13**Eligible Expense** means, with respect to any Coverage Period, an expense that is incurred during such Coverage Period (but not prior to the date benefits commence under the Program), that is eligible for reimbursement pursuant to the terms of the *Program or a Component Plan*, and not otherwise reimbursed to the Participant by any means whatsoever.

~~1.11~~1.14**Employee** means any person other than a nonresident alien who is employed by the Employer as a common law employee and any leased employee within the meaning of Code Section 414(n)(2).

~~1.12~~1.15**Employer** means Clackamas County, a political subdivision of the state of Oregon.

~~1.13~~1.16**FMLA** means the Family and Medical Leave Act of 1993, as amended, and including all related regulations.

~~1.14~~1.17**Full Benefits Employee** means an Eligible Employee who is regularly scheduled to work thirty (30) or more hours per week.

~~1.15~~1.18**Grace Period** means for Plan Years beginning on or after January 1, 2005, amounts remaining in a Participants Flexible Spending Account (Component Plan) at the end of a Plan Year can be used to reimburse the Participant for expenses that are incurred during the period that begins immediately following the close of that Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year under the following conditions:

(a) In order for an individual to be reimbursed for qualified expenses incurred during a Grace Period, he or she must be either (1) a Participant with Flexible Spending Account coverage that is in effect on the last day of that Plan year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under a Health Care Flexible Spending Account on the last day of that Plan Year.

(b) Prior Plan Year Flexible Spending Account amounts may not be cashed out or converted to any other taxable or nontaxable benefit.

(c) Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedures will be reimbursed and charged first against any available prior Plan Year amounts and then against any amounts that are available to reimburse expenses that are incurred during the current Plan Year.

(d) Claims for reimbursement of expenses incurred during a Grace Period must be submitted no later than the date established for claims for reimbursement of expenses incurred during the related Plan Year.

~~1.16~~1.19**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended, and including all related regulations.

~~1.17~~1.20**Nonrepresented Job-Share Employee** means an Eligible Employee who is classified as nonrepresented and shares a full-time job with another Employee and who is regularly scheduled to work at least 18.75 hours per week.

~~1.18~~1.21**Partial Benefits Employee** means an Eligible Employee who is regularly scheduled to work at least twenty (20) but less than thirty (30) hours per week.

~~1.19~~1.22**Participant** means any Eligible Employee who becomes enrolled in the Program pursuant to Section 2.

~~1.20~~1.23**Plan Administrator** means the person or entity authorized to administer the Program pursuant to Section 5.1.

~~1.21~~1.24**Plan Year** means the twelve-month period commencing each January 1 and ending the following December 31.

~~1.22~~1.25**Premium Expense** means the Participant's cost for benefits described in Section 4.1(a). The Premium Expense for a particular benefit is normally set for a Plan Year. However, the Premium Expense for health coverage provided by an independent third party shall be automatically adjusted to reflect a mid-Plan Year benefit cost increase or decrease.

~~Notwithstanding the foregoing, in the event of a USERRA leave of thirty-one (31) days or longer, the Premium Expense for health coverage shall equal the full cost of coverage (Participant and Employer contributions).~~

~~1.23~~1.26**Program** means the Clackamas County Flexible Benefits Program and any Component Plans, collectively, as amended from time to time.

~~1.24~~1.27**Protected Health Information** means information about the past, present or future physical or mental health of a Participant which is protected under HIPAA.

~~1.25~~1.28**Represented Job-Share Employee** means an Eligible Employee who is classified as AFSCME-C-COM, Employees' Association, FOPPO or Housing Authority Employees'

Association and shares a full-time job with another Employee and who is regularly scheduled to work at least 18.75 hours per week.

~~1.26~~1.29**Request for Reimbursement** means the form provided by the Employer for the purpose of claiming reimbursement under any Component Plan.

~~1.27~~1.30**Salary Redirection** means the amount by which a Participant's Compensation shall be reduced pursuant to Section 3.1 and an Annual Electronic Enrollment ~~Form,~~ with the understanding the Employer will contribute such amount to the Program on behalf of the Participant for the purchase of benefits.

~~1.28~~1.31**Salary Redirection Agreement** means an agreement between a Participant and the Employer under which the Participant agrees to reduce his or her Compensation or to forgo increases in such Compensation and to have such amounts contributed by the Employer to the Program on the Participant's behalf. The agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Program and Code Section 125 into account) and, subsequently, does not become currently available to the Participant.

1.32 **Spouse** means the husband or wife of an Eligible Employee, including a same gender spouse when the parties were legally married in a state or country whose laws authorize same gender marriage.

~~1.29~~1.33**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations promulgated pursuant thereto.

SECTION 2
PARTICIPATION

2.1 Annual Enrollment

Each Eligible Employee may enroll in the Program by completing an Annual Electronic Enrollment ~~Form~~ provided by the Plan Administrator. The Annual Electronic Enrollment ~~Form~~ must be submitted to the Plan Administrator during the Election Period effective for the next Coverage Period commencing immediately after the Election Period. The Annual Electronic Enrollment ~~Form~~ shall include a Salary Redirection Agreement and designate the benefits elected. The Annual Electronic Enrollment election made by the Eligible Employee ~~on an Annual Enrollment Form~~ shall be irrevocable until the end of the applicable Coverage Period and the Participant's election of benefits under Section 4.1(a) shall remain in effect for all subsequent Coverage Periods, unless the Participant is entitled to change his or her election pursuant to Section 4.3, all or part of the election is automatically terminated due to a change of employment status, or the Participant submits a new Annual Electronic Enrollment ~~Form~~ during a subsequent Election Period.

2.2 New Eligible Employees

An individual who becomes an Eligible Employee during a Plan Year may elect to participate in this Program for the remainder of such Plan Year by completing an Annual Electronic Enrollment ~~Form~~. The Annual Electronic Enrollment ~~Form~~ may be completed at any time before the last payroll period of the Plan Year.

Such an Employee shall commence participation on the first day of the month coinciding with or following the later of the date he or she:

(a) becomes an Eligible Employee, and

(b) completes an Annual Electronic Enrollment ~~Form~~ within the time period established by the Plan Administrator ~~and such form is processed by the Plan Administrator~~.

A new Eligible Employee who fails to complete an Annual Electronic Enrollment during the Election Period specified by the Plan Administrator will be enrolled in individual coverage in the default plans specified in Appendix A.

2.3 Special Enrollment

(a) Loss of Other Coverage

An Eligible Employee who declined to participate in, or to enroll an eligible dependent in, a group medical benefit option described in Section 4.1(a)(1) during the Election Period due to other health insurance coverage may elect to enroll in a group medical coverage option described in Section 4.1(a)(1) upon loss of the other coverage as described below.

If the other coverage was not COBRA Continuation Coverage, the loss must result from loss of eligibility or termination of employer contributions. Loss of eligibility includes loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment, but does not include any loss due to failure to pay premiums in a timely manner or termination of coverage for cause. If the other coverage was COBRA Continuation Coverage, the loss must be due to exhaustion of such coverage. Application for enrollment must be made ~~on~~ by submitting an Annual Electronic Enrollment ~~Form~~ within sixty (60) days after loss of the other coverage.

Enrollment is effective the first day of the month coinciding with or next following the date of the loss of coverage or the date ~~processing of~~ the Annual Electronic Enrollment ~~Form~~ is completed, whichever occurs later~~, provided enrollment shall be effective not later than the first day of the first calendar~~

~~month beginning after the date the completed Annual Enrollment Form is received by the Plan Administrator~~.

(b) New Dependents

An Eligible Employee who declined to enroll in a group medical benefit option described in Section 4.1(a)(1) during a previous enrollment period may enroll in a group medical benefit option described in Section 4.1(a)(1) if he or she acquires a dependent, as defined in the applicable plan, through marriage, birth, adoption, or placement for adoption or foster care and submits an ~~completed~~ Annual Electronic Enrollment ~~Form to the Plan Administrator~~ within sixty (60) days of the event.

(c) Enrollment of Spouse, Domestic Partner or Dependents

A Participant who elects coverage under Section 2.3(a) or (b) may also enroll his or her spouse or domestic partner and/or dependent(s) in the group medical benefit option described in Section 4.1(a)(1) elected by the Participant by submission of an Annual Electronic Enrollment ~~Form~~ within sixty (60) days of the qualifying loss of other coverage.

A Participant who elects coverage under Section 2.3(a) or (b) may also enroll his or her spouse and/or newly acquired dependent(s) in the group medical benefit option described in Section 4.1(a)(1) elected by the Participant by submission of an Annual Electronic Enrollment ~~Form~~ within sixty (60) days of acquiring the spouse and/or dependent through marriage, birth, adoption, or placement for adoption.

In the case of marriage, enrollment is effective the first day of the month coinciding with or next following the date ~~processing of~~ the Annual Electronic Enrollment ~~Form~~ is completed~~, provided enrollment shall be effective not later than the first day of the month beginning after the date the completed Annual Enrollment Form is received by the Plan Administrator~~. In the case of birth,

enrollment is effective the date of birth. In the case of adoption or placement for adoption or foster care, enrollment is effective the date of such adoption or placement.

2.4 Suspension or Termination of Participation

(a) Termination of Employment

In the event a Participant terminates employment during a Plan Year, participation in this Program shall terminate on the last day of the calendar month in which the Participant terminates employment. All contributions shall terminate upon termination of participation, and all benefits shall terminate at the same time, provided that dependent care expenses incurred during the Plan Year in which termination occurs may continue to be reimbursed in accordance with the dependent care Component Plan. If the individual is rehired within six (6) months after the termination date, he will become an Eligible Employee on the first day of the month following re-employment without regard to the two (2) months of service requirement in Section 1.10 and automatically will have his or her prior benefits election reinstated, unless reinstatement occurs in a new Plan Year, in which case Section 2.2 will apply. A Participant who is rehired more than six (6) months following the termination date will have to complete two (2) additional months of service before becoming an Eligible Employee. A re-hired Participant is not eligible to make new benefit elections until the next Annual Election Period unless an event described in Section 4.3 occurred after the Participant terminated employment. However, any Participant whose employment was terminated as the result of a layoff ~~for medical reasons~~ and who is reinstated to employment, shall have the two (2) month service requirement in Section 1.10 waived when such reinstatements occurs within six (6) months of such layoff, or within eighteen (18) months of such layoff when Participant has continuously participated in COBRA or other continuation coverage during such layoff.

(b) Suspension of Participation

In the event a Participant ceases to be an Eligible Employee, or ceases to have enough Compensation to cover the agreed upon Salary Redirection, but does not terminate employment or take a leave of absence, participation in the Program shall be suspended and shall terminate at the end of the Plan Year if active participation is not reinstated earlier. If the Employee again becomes an Eligible Employee, or has adequate Compensation before the end of the Plan Year, active participation in the Program shall be reinstated, and the most recent Annual Electronic Enrollment ~~Form~~ shall again become effective, subject to any changes permitted pursuant to Section 4.3.

If such an Employee again becomes an Eligible Employee or has adequate Compensation after the end of the Plan Year, he or she may enroll in the Program pursuant to Section 2.2.

During periods of suspended participation, no contributions shall be made pursuant to Section 3, and no benefits elected pursuant to Section 4 shall be provided through this Program unless otherwise required under the ACA.

(c) Leave of Absence

(1) Paid Leave

In the event a Participant takes a paid leave of absence, including paid leave pursuant to the FMLA or USERRA, but does not terminate employment, participation in the Program, including without limitation, Participant contributions and Employer contributions pursuant to Sections 3.1 and 3.2, and benefits elected pursuant to Section 4 shall continue during such leave of absence.

(2) Unpaid Leave

(i) Other Than FMLA or USERRA Leave

In the event a Participant takes an approved, unpaid leave of absence which is not FMLA or USERRA leave, participation shall be suspended in the same manner as participation is suspended in circumstances described in Section 2.4(b).

(ii) FMLA Leave

In the event a Participant takes an unpaid FMLA leave of absence, each elected health benefit shall continue during the unpaid leave but not longer than twelve (12) weeks, and the Employer shall continue to contribute to the Program in accordance with Section 3.2, provided the Premium Expense (if any) for such benefits is timely paid by the Participant. The Premium Expense (if any) ~~shall~~ may be paid on an after-tax basis during an unpaid FMLA leave of absence on the same schedule as payments would be made if the Participant were not on leave.

(iii) USERRA Leave

In the event a Participant takes an unpaid USERRA leave, elected benefits shall be continued for the lesser of the period of the leave or twenty-four (24) months, and the Employer shall continue to contribute to the Program in accordance with Section 3.2, provided the Premium Expense (if any) for such benefits is timely paid by the Participant. The Premium Expense shall be paid on an after-tax basis during the unpaid USERRA leave of absence on the same schedule as payments would be made if the Participant were not on leave.

(3) Return from Leave

Upon return from an unpaid leave of absence before the end of the Plan Year in which the leave commenced, active participation in the Program shall be reinstated and Salary Redirection contributions and benefits shall resume according to the Participant's most recent Annual Electronic Enrollment~~Form~~, including any changes pursuant to Section 4.3.

Upon return from an unpaid leave of absence after the end of the Plan Year, the Participant shall be treated as a newly Eligible Employee and Section 2.2 shall apply.

If the Participant does not immediately resume active employment at the conclusion of a paid or unpaid leave of absence, the Participant shall no longer be considered an Eligible Employee and Section 2.4(a) and (b) shall apply.

2.5 Ordering of Employer Contributions

Employer contributions shall be allocated among the benefit options elected pursuant to the Participant's most recent Annual Electronic Enrollment ~~Form~~, in the following order until exhausted:

(a) medical coverage under Section 4.1(a)(1);

(b) dental coverage under Section 4.1(a)(2);

(c) group term life insurance coverage under Section 4.1(a)(3);

(d) long term disability coverage under Section 4.1(a)(5);

(e) dependent care flexible spending account plan under Section 4.1(c); and

(f) health care flexible spending account plan under Section 4.1(b).

2.6 Leased Employees

Notwithstanding any Program provision to the contrary, the term "Employee" shall have the meaning set forth in Section 1.12 herein. However, a leased employee shall not be eligible to participate in this Program.

SECTION 3
CONTRIBUTIONS

3.1 Salary Redirection

If a Participant elects a benefit described in Section 4.1 pursuant to the applicable election procedure in Section 2, his or her Compensation shall be reduced in an amount equal to his or her Salary Redirection that shall equal the Premium Expense and cost for Component Plan benefits elected. Premium Expense shall be deducted each month and Component Plan costs shall be deducted ratably each pay period from the Participant's Compensation and applied to the benefits elected.

In the event the Premium Expense for health coverage provided by an independent third party changes during a Plan Year, the Salary Redirection amount shall be adjusted automatically to reflect the change in the Premium Expense.

A Participant's maximum Salary Redirection amount for any Plan Year shall equal the maximum cost to the Participant for all benefits that may be elected under the Program.

3.2 Employer Contributions

Prior to the commencement of a Plan Year, the Employer shall determine the monthly amount, if any, to be contributed to the Program by the Employer on behalf of each Participant, in addition to the Salary Redirection amounts during such Plan Year. The amount of the Employer contributions may vary depending on the Participant's status as a Full Benefits Employee, Partial Benefits Employee or Job-Share Employee and whether the employee enrolls a spouse or domestic partner and/or children. If an Eligible Employee becomes a Participant after the first day of the Plan Year, the Employer will credit a pro rata amount towards the Participant's benefits election.

Employer contributions shall be made on behalf of all active Participants and Participants on a paid leave of absence under Section 2.4(c)(1). No Employer contribution shall be made on behalf of a Participant on an unpaid leave of absence

under Section 2.4(c)(2)(i) unless otherwise required under ACA. However, if the unpaid leave is FMLA leave under Section 2.4(c)(2)(ii) or USERRA leave under Section 2.4(c)(2)(iii) and the Participant ~~required~~ contributions for medical coverage, dental coverage, and Health Care Flexible Spending Account Plan benefits are made, then Employer contributions shall be made for such benefits.

3.3 Application of Contributions

The Employer shall credit Salary Redirection amounts and Employer contributions to a bookkeeping account on behalf of each Participant to pay for benefits elected under the Program. Salary Redirection amounts shall be credited as soon as reasonably practical after each payroll period and Employer contributions shall be credited once each month.

3.4 Corrective Procedures to Satisfy Discrimination Tests

If at any time during a Plan Year the Plan Administrator determines that it is necessary to prospectively reduce a Participant's Salary Redirection or the Employer contribution on his or her behalf, or to treat an otherwise nontaxable benefit under the Program as a taxable benefit to satisfy any nondiscrimination requirement or limitation on contributions or benefits imposed by the Code, it shall have the authority to reduce such contributions in such amounts and for the remainder of the Plan Year or any lesser period of time, or report benefits as taxable benefits, to the extent it deems necessary under the circumstances. In the event contributions are reduced, the Plan Administrator shall reduce the Salary Redirection amounts for each affected Participant in the order of the Salary Redirection amounts elected beginning with the highest, then shall reduce the Employer contribution on behalf of each affected Participant in an equal amount; however, if necessary to correct discrimination under a Component Plan, the Employer may first prospectively cease all contributions on behalf of affected Participants to the Component Plan as of a specified date.

SECTION 4
BENEFITS

Benefit Options

Each Participant shall elect to have the amount of his or her Employer contribution and Salary Redirection applied to benefits indicated in the categories set forth below and described in more detail in Appendix A. The coverage options set forth in Appendix A may be amended or terminated at the Employer's discretion, and Appendix A may be amended accordingly without necessity for other amendment of the Program document.

The terms and conditions of the coverage options set forth in Appendix A are set forth in separate documents. The insurer, contract number, or funding method of providing the following group coverages may change from time to time. The group coverage and contract, as modified from time to time, shall be incorporated herein by reference. However, the terms and conditions of any such group coverage shall be determined solely from the documents under which group coverage is provided and are not affected by the terms of this Program. Such group coverages are affected by the terms of this Program only to the extent of electing the coverages provided to a Participant.

Options (b) and (c) provide reimbursement of expenses under a Component Plan.

Cash pursuant to option (d), group term life coverage in excess of $50,000 pursuant to option (a)(3), and the value of health care premiums for domestic partners and their children pursuant to options (a)(1) and (a)(2) shall be reported as taxable benefits as required by Federal and State laws, regulations and rules. All other benefits shall be reported as nontaxable benefits, subject to the provisions of any Component Plan and any adjustment made pursuant to Section 3.4.

(a) Group Benefits

Each Participant may elect to have his or her contributions applied to pay Premium Expenses for coverage of the Participant and Participant's dependents (including a Domestic Partner), if any, under the Employer-sponsored group plans set forth below:

(1) Medical, Prescription Drug, and Vision Coverage

Each Participant who is a Full Benefits Employee, Partial Benefits Employee or Represented Job Share Employee shall choose one of the combined medical, prescription drug and vision coverages set forth in Appendix A. However, in the event the Participant provides proof of coverage under another combined medical, prescription drug and vision plan, the employee may opt out of coverage. Each Participant who is a Nonrepresented Job Share employee may choose one of the combined medical, prescription drug and vision coverages set forth in Appendix A.

(2) Dental Coverage

Each Participant ~~who is a Full Benefits Employee or a Represented Job Share Employee shall choose one of the dental coverages set forth in Appendix A. Each Participant who is a Partial Benefits Employee or a Nonrepresented Job Share Employee~~ may choose one of the dental coverages set forth in Appendix A or may choose to opt out of dental coverage.

(3) Group Term Life Coverage

Each Participant who is a Full Benefits Employee or a Represented Job-Share Employee shall choose a level of group term life insurance coverage set forth in Appendix A.

(4) Long Term Disability Coverage

Each Participant who is a Full Benefits Employee or a Job-Share Employee may choose supplemental long-term disability coverage in an amount set forth in Appendix A.

(b) Health Care Flexible Spending Account Plan Benefit

Each Participant may choose reimbursement of health care expenses as provided under a Component Plan.

(c) Dependent Care Flexible Spending Account Plan Benefit

Each Participant may choose reimbursement of dependent care expenses as provided under a Component Plan.

(d) Cash Benefit

If a Participant has remaining contributions after choosing benefits under (a), (b), and (c) above, excess amounts may be distributed in cash.

4.2 Benefits Election

Subject to the conditions and limitations of the Program and any Component Plan, a Participant shall elect a combination of options having a value equal to the total Employer contributions and Salary Redirection made on his or her behalf during the Plan Year. Options specified in Section 4.1(a) shall be assigned individual premiums which shall be set forth in Appendix A to the Program. The reimbursement plan options pursuant to Sections 4.1(b) and (c) shall have a value equal to the dollar amount elected by a Participant.

A Participant shall specify the portion of his or her account for a Plan Year that shall be designated for each option, subject to any mandatory coverage. Amounts designated for a particular option shall be available only for that option and, if not spent for such option during the Plan Year or a subsequent Grace Period, shall be forfeited and retained by the Employer. Reimbursement of an Eligible Expense pursuant to a

Component Plan shall be deemed a benefit for a particular Coverage Period if the Eligible Expense is incurred during such Coverage Period and a Request for Reimbursement of the Eligible Expense is submitted within the required time.

4.3 Change of Election

(a) Health and Life Coverage Election Changes

(1) Changes in Status

(A) A Participant may change a benefit election for health and life coverage after the Coverage Period (to which such election relates) has commenced and make a new election with respect to the remainder of such Coverage Period if the change is permitted by the terms and conditions of the applicable Employer-sponsored coverage described in Section 4.1(a) and is on account of and "consistent with" (as described in Section 4.3(a)(1)(B) below) one of the following family or employment status changes:

(i) legal marital status: including marriage, death of spouse, divorce, legal separation, or annulment;

(ii) number of dependents (as defined in Code Section 152): including birth, adoption, placement for adoption or foster care, or death of a dependent;

(iii) employment status: a termination or commencement of employment by the Participant, ~~spouse~~Spouse, Domestic Partner, or ~~dependent~~Dependent;

(iv) work schedule: a reduction or increase in hours of employment by the Participant, ~~spouse~~Spouse, Domestic Partner, or ~~dependent~~Dependent, including a switch between part-time and full-time, a strike or lockout, or

commencement or return from an unpaid leave of absence;

(v) ~~unmarried~~ a ~~dependent~~ Dependent (including a Domestic Partner) satisfies or ceases to satisfy the health plan coverage eligibility requirements~~:~~ due to age limits~~,~~ ~~student status,~~ or similar circumstances;

(vi) residence or work site: a change in the place or residence or work of the Participant, ~~spouse~~Spouse, Domestic Partner or ~~dependent~~Dependent.

For purposes of this Section 4.3, health coverage is described in Section 4.1(a)(1) (medical, prescription drugs, and vision coverage) and (2) (dental coverage), and in Section 4.1(b) (health care flexible spending account plan). Life coverage is coverage described in Section 4.1(a)(3) (group term life coverage).

(B) "Consistent With"

No election changes are permitted due to an event in Section 4.3(a)(1)(A) unless the change is "consistent with" the reason for the change as described in this Section 4.3(a)(1)(B).

For health coverage purposes, an election change is "consistent with" a status change only if the event described in Section 4.3(a)(1)(A) above causes a gain or loss of eligibility for health coverage either under the Program or a health plan sponsored by the spouse's, Domestic Partner's or dependent's employer (and provided, if eligibility under another health plan is gained, the other coverage is elected). A Participant may be considered to have gained (lost) eligibility if the Participant becomes eligible (ineligible) for a particular health coverage

option due to the event. Any election change must correspond to the gain or loss of coverage.

For life insurance coverage purposes, in the case of marriage, birth, adoption, or placement for adoption, an election change can only increase the amount of the employee's life insurance coverage. In the case of divorce, legal separation, annulment, or death of a spouse, Domestic Partner or dependent, an election change can only reduce the amount of the employee's life insurance. No other changes are considered "consistent with" an event.

(2) Other Health and Life Election Change Events

(A) Special enrollment period: a Participant may change his or her health coverage election during the sixty (60) day special enrollment period described in Section 2.3.

(B) Change in health coverage due to spouse's or Domestic Partner's employment: a Participant may change his or her health coverage election consistent with a significant change in the health coverage of the Participant or spouse or Domestic Partner attributable to the spouse's or Domestic Partner's employment.

(C) Cost increase: if a Participant elects Premium Expenses for a health coverage which is insured or provided by a health maintenance organization (HMO) and the insurer or HMO significantly increases the cost of coverage during the Coverage Period, the Participant may change his or her benefit election to the Premium Expense for another similar coverage provided in Section 4.1(a) for the remainder of the Coverage Period. In this circumstance, a Participant may not waive coverage for the remainder of the Coverage Period.

(D) Coverage change: if a Participant elects Premium Expenses for a health coverage which is insured or provided by a health maintenance organization (HMO) and the insurer or HMO significantly curtails or ceases coverage during a Coverage Period, the Participant may change his or her benefit election to the Premium Expense for another similar coverage provided in Section 4.1(a) for the remainder of the Coverage Period. In this circumstance, a Participant may not waive coverage for the remainder of the Coverage Period.

(E) Judgment, decree, or order: a Participant may change an election to provide or cancel health coverage for the Participant's child in accordance with a judgment, decree, or court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order).

(F) COBRA: a Participant may elect to increase contributions to this Program to pay for COBRA Continuation Coverage for the Participant, spouse, or dependent (as defined in Code Section 152).

(G) Medicare or Medicaid Entitlement: a Participant may elect to cancel health coverage for the Participant, spouse, Domestic Partner or dependent who becomes entitled to coverage under Part A or Part B of Medicare or under Medicaid.

(b) Election Changes for Benefits Other than Health and Life

A Participant may change a benefit election for benefits other than health or life coverage after the Coverage Period (to which such election relates) has commenced and make a new election with respect to the remainder of such Coverage Period if the change is permitted by the terms and conditions of the applicable Employer-sponsored coverage described in Section 4.1 and is

necessary due to, or is appropriate with, a change in family or employment status which for purposes of this Section 4.3(b) includes, without limitation:

(1) marriage;

(2) divorce;

(3) termination of domestic partnership;

(4) death of the Participant's spouse, Domestic Partner or dependent;

(5) birth or adoption of a child;

~~**(5)**~~**(6)** placement of a foster child;

~~**(6)**~~**(7)** termination or commencement of a spouse's or Domestic Partner's employment;

~~**(7)**~~**(8)** the Participant, spouse or Domestic Partner changing from part-time to full-time employment status (or vice versa); or

~~**(8)**~~**(9)** the Participant, spouse or Domestic Partner taking an unpaid leave of absence.

(c) Election Period

For election changes other than changes in health coverage, the election change shall become effective for the first of the month following ~~receipt and processing~~ submission of the election change request ~~by~~ to the Plan Administrator. An election change request must be submitted to the Plan Administrator within sixty (60) days after the applicable event allowing the change occurs.

For changes in health coverage, the change shall be effective as of the date described in the plan documents applicable to the elected health coverage. An election change request must be submitted to the Plan Administrator within sixty (60) days after the applicable event allowing the change occurs.

4.4 Payment of Premiums and Reimbursements

The Employer shall forward premiums as soon as administratively feasible, and not less often than monthly, to the appropriate insurance carrier, health maintenance organization, or funding vehicle for elected coverages. Eligible Expenses shall be reimbursed as soon as practical following receipt of a Request for Reimbursement, subject to the terms of the Component Plan. An Eligible Expense shall be reimbursable pursuant to the terms of the Program and a Component Plan only during the Coverage Period in which it is incurred, provided that an Eligible Expense incurred during a Coverage Period may be reimbursed if a Request for Reimbursement of the expense is submitted within ninety (90) days following the end of the Plan Year (or ninety (90) days following the end of the Grace Period).

4.5 Maximum Disbursement

Except as otherwise provided in a Component Plan, disbursements for an option under Section 4.1 shall never exceed the portion of such Participant's account balance which is designated for such option.

SECTION 5
ADMINISTRATION

5.1 Plan Administration

The Employer shall be the Plan Administrator of the Program.

5.2 Duties and Authority of Plan Administrator

(a) Administrative Duties

The Plan Administrator shall administer the Program in a nondiscriminatory manner for the exclusive benefit of Participants and their beneficiaries. The Plan Administrator shall perform all such duties as are necessary to supervise the administration of the Program and to control its operation in accordance with the terms thereof, including, but not limited to, the following:

(1) Make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Program;

(2) Interpret the provisions of the Program and determine any question arising under the Program, or in connection with the administration or operation thereof;

(3) Determine all considerations affecting the eligibility of any Employee to be or become a Participant;

(4) Determine eligibility for and amount of benefits for any Participant;

(5) Authorize and direct all disbursements of benefits under the Program;

(6) Employ and engage such persons, counsel, and agents and obtain such administrative, clerical, medical, legal, audit, and actuarial services as it may deem necessary in carrying out the provisions of the Program; and

(7) Delegate and allocate specific responsibilities, obligations, and duties imposed by the Program, to one or more employees, officers, or such other persons as the Plan Administrator deems appropriate.

(b) General Authority

The Plan Administrator shall have all powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Program and the facts and circumstances of claims for benefits. Any interpretation or construction of or action by the Plan Administrator with respect to the Program and its administration shall be conclusive and binding upon any and all parties and persons affected hereby.

5.3 Forms

All forms and other communications from any Participant or other person to the Plan Administrator required or permitted under the Program shall be in the form prescribed from time to time by the Plan Administrator, shall be mailed by first-class mail or delivered, including electronic delivery ~~by facsimile transmission, telex, or telegram,~~ to the location specified by the Plan Administrator, and shall be deemed to have been given and delivered only upon actual receipt thereof. Each Participant shall ~~file~~ submit ~~with an Annual Enrollment Form such~~ pertinent information as the Plan Administrator may specify.

5.4 Examination of Documents

The Plan Administrator shall make available to each Participant such documents and records as pertain to the Participant for examination at reasonable times during normal business hours.

5.5 Participant Accounts

The Plan Administrator shall maintain an Employer bookkeeping account or accounts on behalf of each Participant showing the fiscal transactions of the Program with respect to each Participant.

5.6 No Assets

Notwithstanding any Program provision to the contrary, no assets shall be segregated for the purpose of providing benefits under the Program. All benefits are payable solely from the Employer's general assets. A Participant has only an unsecured contract right to receive payments under the terms of the Program.

Any contributions pursuant to a Salary Redirection Agreement are merely held in an account and remain available to the Employer's general creditors. Participant accounts are a record keeping device, and any funds in such accounts are general assets of the Employer. No interest shall be credited to any Participant's account.

5.7 Reports

The Plan Administrator shall file or cause to be filed all annual reports, returns, and financial or other statements required by any federal or state statute, agency, or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements, or other documents to such Participants and beneficiaries as required by federal or state statute or regulation, within the time prescribed for furnishing such documents.

5.8 Expenses

All expenses incurred in connection with administration of the Program shall be paid by the Employer.

5.9 Claim Procedure

The following claims procedures shall apply:

(a) Notice of Denial

Any time a claim for benefits is wholly or partially denied, the Participant or beneficiary (hereinafter "Claimant") shall be given written notice of such action within ninety (90) days after the claim is filed unless special circumstances require an extension of time for processing. If there is an extension, the

Claimant shall be notified of the extension and the reason for the extension within the initial ninety (90) day period. The extension shall not exceed one hundred eighty (180) days after the claim is filed. Such notice will indicate the reason for denial, the pertinent provisions of the Program on which the denial is based, an explanation of the claims appeal procedure set forth herein, and a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.

(b) Right to Request Review

Any person who has had a claim for benefits denied by the Plan Administrator or is otherwise adversely affected by action of the Plan Administrator, shall have the right to request review by the Plan Administrator. Such request must be in writing, and must be made within sixty (60) days after such person is advised of the Plan Administrator's action. If written request for review is not made within such sixty (60) day period, the Claimant shall forfeit his or her right to review. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments in writing.

(c) Review of Claim

If a request for review is received in a timely manner, the Plan Administrator shall then review the claim. It may hold a hearing if it deems it necessary and shall issue a written decision reaffirming, modifying, or setting aside its former action within sixty (60) days after receipt of the written request for review, or one hundred twenty (120) days if special circumstances, such as a hearing, require an extension. The Claimant shall be notified in writing of any such extension within sixty (60) days following the request for review. A copy of the decision shall be furnished to the Claimant. The decision shall set forth its reasons and pertinent Program provisions on which it is based. The decision shall be final and binding upon the Claimant and the Plan Administrator and all other persons involved.

5.10 Health Insurance Portability & Accountability Act (HIPAA)

The Program shall protect the confidentiality of Participants' Private Health Information and enforce Participants' rights under HIPAA. The Program, and Plan Administrator, will not use or disclose Protected Health Information except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Program has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Program will not, without authorization, use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer. The Program will allow Participants' to view and copy their Protected Health Information, receive an accounting of certain disclosures of their Protected Health Information and, under certain circumstances, amend the information. In addition, the Program maintains a privacy notice which provides a complete description of Participants' rights under HIPAA's privacy rules, including the right to file a complaint with the Program or with the Secretary of the U.S. Department of Health and Human Services if they believe their rights under HIPAA have been violated.

Participants who lose medical coverage under the Program will be provided with a certificate of creditable coverage as required under HIPAA.

SECTION 6
AMENDMENT AND TERMINATION

6.1 Amendment or Termination

The Employer establishes this Program with the intention that it will be maintained indefinitely. However, the Employer reserves the right at any time and from time to time to amend any or all provisions of the Program, or terminate the Program, and/or any contributions under the Program, in whole or in part, for any reason and without consent of any person, and without any liability to any person for such amendment or termination of the Program, provided that the payment of claims that are incurred prior to the time of such amendment or termination of the Program shall not be adversely affected. Any amendment shall be authorized by the Board of County Commissioners of the Employer, made in writing, and executed by a duly authorized officer of the Employer. Nothing in this Program shall be construed to require continuation of this Program with respect to existing or future Participants or beneficiaries.

In the event the Program or a Component Plan is terminated, no further Employer contributions or Salary Redirection with respect to the Program or the Component Plan, whichever applies, shall be made.

Amounts designated for Premium Expenses shall be applied to pay Premium Expenses for the remainder of the Plan Year in which termination of the Program occurs, or until such amount is reduced to zero (0) if earlier.

Amounts designated for the Dependent Care Flexible Spending Account Component Plan shall be used to reimburse Eligible Expenses under that plan that are incurred during the remainder of the Plan Year in which termination of the Program occurs or until the balance is reduced to zero (0) if earlier. Eligible Expenses shall be reimbursed under the Dependent Care Flexible Spending Account Component Plan following termination of the Program provided that a Request for Reimbursement is submitted

within ninety (90) days after the end of the Plan Year in which termination of the Program occurs.

Health Care Flexible Spending Account Component Plan coverage shall provide reimbursement of Eligible Expenses under that plan that are incurred prior to the date of termination of the Program. Such Expenses shall be reimbursed only if the Request for Reimbursement is submitted within ninety (90) days after the date of termination of the Health Care Flexible Spending Account Component Plan.

SECTION 7
GENERAL PROVISIONS

7.1 Plan Interpretation

This document and all appendices and amendments, including Component Plan documents, set forth the provisions of the Program. This Program shall be read in its entirety and not severed except as provided in Section 7.8.

7.2 Participation by Affiliated Employers

The Employer may permit any of its subsidiaries or affiliates to participate in the Program. Any such participating employer, and the period of time during which it participates, shall be listed in appendices to the Program.

7.3 No Additional Rights

No person shall have any legal or equitable rights against the Employer or the Plan Administrator, except as, and only to the extent, expressly provided for in the Program or by law. Neither the establishment or amendment of the Program or the creation of any fund or account, or the payment of benefits, nor any action of the Employer or the Plan Administrator shall be held or construed to confer upon any person any right to be continued as an Employee or to affect his or her terms of employment in any way or, upon dismissal, to confer any right or interest in any account or fund other than as provided under the terms of the Program and any Component Plan. The Employer expressly reserves the right to discharge any Employee at any time.

7.4 Other Salary-Related Plans

It is intended that any other salary-related Employee benefit plans that are maintained or sponsored by the Employer shall not be affected by this Program. Any contributions or benefits under such other plans with respect to a Participant shall, to the extent permitted by law and applicable Plan documents, be based on his or her Compensation from the Employer, including any Salary Redirection amounts.

7.5 Representations

The Employer does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security, or other tax consequences will result from participation in the Program and Component Plans. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

7.6 Notice

All notices, statements, reports, and other communications from the Employer to any Employee or other person required or permitted under the Program and the Component Plans shall be deemed to have been duly given when delivered to, or when mailed by first-class mail, postage prepaid and addressed to such Employee or other person at his or her address last appearing on the Employer's records.

7.7 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun shall include the opposite gender and the singular shall include the plural, and the plural shall include the singular, whenever the context shall plainly so require.

7.8 Severability

If any provision of this Program is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of this Program, which shall be construed as if the illegal or invalid provisions had never been included.

7.9 Governing Law

This Program and the Component Plans shall be construed in accordance with the applicable federal law and, to the extent otherwise applicable, the laws of the state of Oregon.

7.10 Disclosure to Participants

Each Participant shall be advised of the general provisions of the Program, and, upon written request addressed to the Plan Administrator, shall be furnished any information requested regarding the Participant's status, rights, and privileges under the Program as may be required by law.

7.11 Accounting Period

The accounting period for the Program shall be a fiscal year beginning on July 1 and ending on June 30.

7.12 Facility of Payment

In the event any benefit under this Program shall be payable to a person who is under legal disability or is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian, committee, or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage for such person's benefit. Any payment made in good faith pursuant to this provision shall fully discharge the Employer and the Program of any liability to the extent of such payment.

7.13 Correction of Errors

In the event an incorrect amount is paid to or on behalf of a Participant or Beneficiary, any remaining payments may be adjusted to correct the error. The Plan Administrator may take such other action it deems necessary and equitable to correct any such error.

7.14 Counting of Days

Any period of time described in this Program as a number of days shall mean the corresponding number of consecutive days, unless the context specifically indicates otherwise.

The Clackamas County Flexible Benefits Program, as amended and restated herein, is adopted by Clackamas County effective January 1, ~~2005~~2014.

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

FOR CLACKAMAS COUNTY

By the Board of County Commissioners:

_____

Chair

_____

Recording Secretary

APPENDIX A

This appendix describes the benefits options available under Section 4.1(a) and the Employee's monthly cost for such coverage, effective January 1, 2014.

A. Medical, prescription drug, and vision coverage options under Section 4.1(a)(1) of the Program:

General County/Housing Authority
Full Benefits/Partial Benefits
Nonrepresented Employees
Tiered Rates

		Premium Expense		
Option	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
1. Kaiser Permanente**				
2. Providence Open Option				
3. Providence Personal Option				
4. Opt Out (Cash Back)				

General County/Housing Authority
Full Benefits/Partial Benefits
AFSCME, Employees Association, FOPPO
Composite Rates

		Premium Expense		
Option	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
5. Kaiser Permanente**				
6. Providence Open Option				
7. Providence Personal Option				
8. Opt Out Provision				

Peace Officers Association
Full Benefits/Partial Benefits Employees
Composite Rates

		Premium Expense*		
Option	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
9. Kaiser Permanente**				
10. Providence Open Option				
11. Providence Personal Option				

**Default option

General County/Housing Authority Nonrepresented Job Share Employees Tiered Rates				
		Premium Expense		
Option	Employee Only	Employee & Spouse	Employee & Child/ren	Family
12. Kaiser Permanente				
13. Providence Open Option				
14. Providence Personal Option				

General County/Housing Authority Represented Job Share Employees Tiered Rates				
		Premium Expense		
Option	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
15. Kaiser Permanente**				
16. Providence Open Option				
17. Providence Personal Option				
18. Opt Out (Cash Back)				

B. Dental coverage options under Section 4.1(a)(2) of the Program:

General County/Housing Authority Nonrepresented Employees Full Benefits Tiered Rates				
		Premium Expense		
Option	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
1. Kaiser Permanente	$0.00	$0.00	$0.00	$0.00
2. ODS Preventive**	$0.00	$0.00	$0.00	$0.00
3. ODS Incentive	$0.00	$0.00	$0.00	$0.00
4. ODS 50% (cash back)				

**Default option

General County/Housing Authority
AFSCME, Employees Association, FOPPO
Full Benefits
Tiered Rates

Option	Premium Expense			
	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
5. Kaiser Permanente	$0.00	$0.00	$0.00	$0.00
6. ODS Preventive**	$0.00	$0.00	$0.00	$0.00
7. ODS Incentive	$0.00	$0.00	$0.00	$0.00
8. ODS 50% (cash back)	$0.00	$0.00	$0.00	$0.00

Peace Officers Association
Full Benefits
Tiered Rates

Option	Premium Expense			
	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
9. Kaiser Permanente	$0.00	$0.00	$0.00	$0.00
10. ODS Incentive**	$0.00	$0.00	$0.00	$0.00

General County/Housing Authority
Nonrepresented Employees
Job Share Benefits
Tiered Rates

Option	Premium Expense			
	Employee Only	Employee & Spouse	Employee & Child/ren	Family
11. Kaiser Permanente				
12. ODS Preventive**				
13. ODS Incentive				
14. ODS 50%				

**Default option

General County/Housing Authority
Employees Association, FOPPO
Job Share Benefits
Tiered Rates

Option	Premium Expense			
	Employee Only**	Employee & Spouse	Employee & Child/ren	Family
15. Kaiser Permanente				
16. ODS Preventive**				
17. ODS Incentive				
18. ODS 50%				

General County/Housing Authority
Nonrepresented, AFSCME, Employees Association, FOPPO
Partial Benefits
Tiered Rates

Option	Premium Expense			
	Employee Only	Employee & Spouse	Employee & Child/ren	Family
1. Kaiser Permanente				
2. ODS Preventive**				
3. ODS Incentive				
4. ODS 50%				

Peace Officers Association
Partial Benefits
Tiered Rates

Option	Premium Expense			
	Employee Only	Employee & Spouse	Employee & Child/ren	Family
19. Kaiser Permanente				
20. ODS Incentive**				

**Default option

C. Group term life coverage under Section 4.1(a)(3) of the Program is available in the following coverage amounts:

		Premium Expense*		
		General	HA	Job Share/ Partial Benefits
1.	Non-Represented Employees			
	a. Basic Coverage ($150,000)**	$0.00	$0.00	N/A
	b. Reduced Coverage ($50,000)	($24.00)	($24.00)	N/A
2.	Represented Employees			
	a. AFSCME-CCOM, AFSCME-DTD, AFSCME-WES, EA, HA/EA, FOPPO ($50,000)	$0.00	$0.00	$0.00
	b. Job Share ($25,000)			
3.	Peace Officers Association ($75,000)	$0.00	N/A	N/A

*Numbers in parenthesis indicate cash-back to Participant.

D. Short and Long Term Disability Coverage under Section 4.1(a)(4) is provided by the employer in an amount equal to sixty percent (60%) of pre-disability earnings up to a maximum covered salary of $3,333 per month for Full Benefits, Nonrepresented Job Share, Represented Job Share and POA employees.

Supplemental Short and Long Term Disability Coverage may be purchased in an amount equal to sixty percent (60%) of pre-disability earnings in excess of $3,333 per month and less than or equal to $10,000 per month for POA employees and $3,333 per month and less than or equal to $8,333 per month for all other eligible employees. The rate is $0.64 per $100 of covered salary for POA and $0.57 for all other employees.

**Default option

Clackamas County

Health Care Flexible Spending Account Plan

A Component Plan of the
Clackamas County
Flexible Benefits Program

AMENDED AND RESTATED

Effective January 1, ~~2009~~ 2014

Table of Contents

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, ~~2009~~2014, 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, ~~2005~~ 2009 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, ~~2009~~2014, 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 incured (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) unmarried child under twenty-one (21) years of age;~~

~~(b) unmarried child under twenty five (25) years of age who is a full-time student at an accredited college, university, or school;~~

~~(c)~~(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

~~(d)~~(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 ~~Form~~ 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 between the amount elected and actual reimbursement shall be forfeited.

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.

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.

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; 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, ~~2009~~2014.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed on this _____ day of _____, ~~2009~~2013.

FOR CLACKAMAS COUNTY

By the Board of County Commissioners:

_____
Chair

_____
Recording Secretary