Memo

Date: February 8, 2022
To: Clackamas County Board of Commissioners
From: Human Resources – Kristi Durham, Benefits Manager

Subject: Benefit Renewals for 2022

Human Resources is seeking formal approval to renew benefit plans with providers for the 2022 calendar year, as well as approval of the 2022 non-represented cost sharing arrangement. Final plan documents are in the process of being prepared by providers. When completed, they will be reviewed and approved by County Counsel prior to submission to the Board for formal adoption at a future business meeting.

This Issues Session will update the Board on 2022 benefit plan renewals, including final plan design, language changes, rates, and benefit cost shares.

Medical/Vision:
There are approximately 1,645 employees and early retirees enrolled in the General County medical plans. The 2022 General County Providence renewal rates increased 1.9%, and the 2022 Kaiser renewal rates increased 4.3%.

The Benefits Review Committee chose to make the following plan design changes to the General County Providence and Kaiser Medical and Vision plans for the 2022 plan year:

- General County Providence Medical/Vision Plans:
  - Add vision therapy coverage and increase frame and contact lenses allowance from $130 to $175 per covered individual.
  - Removed annual dollar maximum for alternative care benefits (2021 annual maximum of $2,000). Implemented the following annual visit limit for alternative care:
    - Naturopath: No visit limit, billed as primary care visit
    - Chiropractic: 30 visits
    - Acupuncture: 30 visits
    - Massage: 30 visits
- General County Kaiser Medical/Vision Plan:
  - Increased annual deductible from $250 to $350
  - Increased annual out-of-pocket maximum from $1,000 to $1,500
  - Removed annual dollar maximum for alternative care benefits (2021 annual maximum of $1,500). Implemented the following annual visit limit for alternative care:
    - Naturopath: No visit limit, billed as primary care visit
    - Chiropractic: 20 visits
    - Acupuncture: 12 visits
    - Massage: 12 visits

There are approximately 495 employees and early retirees enrolled in the Peace Officers Association (POA) medical plans. The 2022 Providence POA renewal rates decreased 12.6%, and the 2022 Kaiser POA renewal rates increased 6.3%. The Joint Peace Officers/County Benefits Committee chose to make the following plan design changes to the POA Providence and Kaiser medical and vision plans for the 2022 plan year:

- POA Providence Medical/Vision Plans:
    - Added naturopath, acupuncture and massage benefits. Removed annual dollar maximum for alternative care benefits (2021 annual maximum of $1,500). Implemented the following annual visit limit for alternative care:
        - Naturopath: No visit limit, billed as primary care visit
        - Chiropractic: 30 visits
        - Acupuncture: 30 visits
        - Massage: 30 visits
- POA Kaiser Medical/Vision Plan:
    - Removed annual dollar maximum for alternative care benefits (2021 annual maximum of $1,500). Implemented the following annual visit limit for alternative care:
        - Naturopath: No visit limit, billed as primary care visit
        - Chiropractic: 20 visits
        - Acupuncture: 12 visits
        - Massage: 12 visits

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

The medical opt-out cash back amounts are remaining the same for all groups in 2022.

Dental:
The General County self-insured dental plans experienced an average rate increase of 1.0%, and the POA self-insured dental plan experienced a rate increase of 6.0%. The Kaiser dental plan for General County and POA had no change in total premium. The BRC and did not make any plan design changes to the dental plans for the 2022 plan year. The Joint Peace Officers/County Benefits Committee chose to make the following plan design changes to the POA Delta Dental plans for the 2022 plan year:

- POA Delta Dental (MODA/ODS) Incentive Plan:
    - Added occlusal guard coverage at 100% up to $250 maximum every 5 years.

The dental opt-out cash back amount is remaining the same for all groups in 2022.

Other Benefits:
All life insurance products (group term life, group universal life, accidental death & dismemberment, and dependent term life insurance), Navia flexible spending account (FSA), short-term and long-term disability plans, and long-term care will retain the same rates as 2021.

Represented Employee Cost-Sharing:
Represented employee cost sharing is defined in the collective bargaining agreements (CBA) of each union. Under the AFSCME, EA and FOPPO CBAs, the County pays 95% of the monthly composite premium for each medical plan up to a maximum of 105% of the previous year's County contribution.

New EA and AFSCME contracts are still undergoing negotiation, so EA and AFSCME employee medical plan contributions will be adjusted based on the new union contract language after contracts are ratified.

Under the POA CBA, the County pays 95% of the composite premium rate for Providence medical plans and the employee agrees to pay 5% of the premium costs. However, if the premium increases more than 10% in any one year, the County and the POA employees shall evenly split the increased costs above 10%. The County pays 100% of the premium for POA employees enrolled in the Kaiser medical plan. The County pays 100% of the dental, life and disability premiums and the administrative costs for the Navia FSA.

Non-Represented Employee Cost-Sharing:
The current practice for non-represented 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 Navia FSA.

FINANCIAL IMPLICATIONS

This item is in the Human Resources current budget. The General Fund does not pay the benefit premiums or increases noted below. The funding is through contributions and fees paid by county departments, employees, retirees, COBRA beneficiaries, and other agencies contracting with Clackamas County for employee benefits administration.
The estimated fiscal impact for the 2022 plan year based on current enrollment is:

Medical/Vision:	$ 43,537,786.00 (increase of approximately $338,000 from 2021)
Dental:	$ 4,377,792.00 (decrease of approximately $2,000 from 2021; decrease is due to changes in enrollment)
Opt-out cash back:	$ 504,828.00 (increase of approximately $18,000 from 2021 estimate due to changes in enrollment)
Group Term Life:	$ 198,398.40
Disability (STD):	$ 265,708.00
Navia FSA Admin:	$ 39,613.80

STRATEGIC PLAN ALIGNMENT

This project directly supports Human Resource's Strategic Result #5 to align wellness programs with workforce needs.

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

OPTIONS

1. Approve 2022 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

2. Approve non-represented employee cost sharing arrangement with changes. Approve 2022 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia and move it forward for formal adoption at a future business meeting.

3. Do not approve 2022 renewals and/or non-represented employee cost sharing arrangement.

RECOMMENDATION

Staff recommends option 1: Approve 2022 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

ATTACHMENTS

1. 2022 Rate Chart (Exhibit A)
2. Clackamas County General County 2022 Renewal Report (Exhibit B)
3. Clackamas County POA 2021 Renewal Report (Exhibit C)

2022	NONREPRESENTED				REPRESENTED (EA & AFSCME)				PEACE OFFICERS			
MEDICAL												
	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family
Kaiser												
Employer	669.54	1,339.02	1,205.14	2,008.54	629.66	1,334.40	1,193.46	2,039.16	733.50	1,467.00	1,320.30	2,200.50
Employee	35.22	70.48	63.42	105.72	75.10	75.10	75.10	75.10	-	-	-	-
	704.76	1,409.50	1,268.56	2,114.26	704.76	1,409.50	1,268.56	2,114.26	733.50	1,467.00	1,320.30	2,200.50
Composite Equivalent				1,501.90				1,501.90				1,672.98
Employer							95%	1,426.80				
Employee								75.10				
Providence Personal Option/VSP Vision												
Employer	752.40	1,504.80	1,356.60	2,260.04	683.02	1,475.02	1,319.02	2,270.02	624.26	1,333.26	1,193.26	2,045.26
Employee	39.60	79.20	71.40	118.96	108.98	108.98	108.98	108.98	84.74	84.74	84.74	84.74
	792.00	1,584.00	1,428.00	2,379.00	792.00	1,584.00	1,428.00	2,379.00	709.00	1,418.00	1,278.00	2,130.00
Composite Equivalent				1,699.00				1,699.00				1,695.00
Employer							94%	1,590.02				1,610.26
Employee								108.98				84.74
Providence Open Option/VSP Vision												
Employer	830.30	1,658.70	1,496.24	2,489.00	657.00	1,529.00	1,358.00	2,403.00	666.82	1,423.82	1,274.82	2,183.82
Employee	43.70	87.30	78.76	131.00	217.00	217.00	217.00	217.00	92.18	92.18	92.18	92.18
	874.00	1,746.00	1,575.00	2,620.00	874.00	1,746.00	1,575.00	2,620.00	759.00	1,516.00	1,367.00	2,276.00
Composite Equivalent				2,021.00				2,021.00				1,844.00
Employer							89%	1,804.00				1,751.82
Employee								217.00				92.18
Medical Opt Out - Cash Back	83.00	164.00	148.00	247.00	185.00	185.00	185.00	185.00				
Medical Opt Out - HRA Contribution									176.00	176.00	176.00	176.00

2022	REPRESENTED (FOPPO)			
MEDICAL				
	Single	Married	Single w/ Child/ren	Family
Kaiser				
Employer	629.66	1,334.40	1,193.46	2,039.16
Employee	75.10	75.10	75.10	75.10
	704.76	1,409.50	1,268.56	2,114.26
Composite Equivalent				1,501.90
Employer			95%	1,426.80
Employee				75.10
Providence Personal Option/VSP Vision				
Employer	707.06	1,499.06	1,343.06	2,294.06
Employee	84.94	84.94	84.94	84.94
	792.00	1,584.00	1,428.00	2,379.00
Composite Equivalent				1,699.00
Employer			95%	1,614.06
Employee				84.94
Providence Open Option/VSP Vision				
Employer	747.20	1,619.20	1,448.20	2,493.20
Employee	126.80	126.80	126.80	126.80
	874.00	1,746.00	1,575.00	2,620.00
Composite Equivalent				2,021.00
Employer			94%	1,894.20
Employee				126.80
Medical Opt Out - Cash Back	185.00	185.00	185.00	185.00
Medical Opt Out - HRA Contribution				

	NONREPRESENTED				REPRESENTED				PEACE OFFICERS			
DENTAL												
Kaiser												
Employer	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Composite:				192.00				192.00				192.00
MODA Preventive												
Employer	85.00	171.00	122.00	209.00	85.00	171.00	122.00	209.00				
Employee	-	-	-	-	-	-	-	-				
	85.00	171.00	122.00	209.00	85.00	171.00	122.00	209.00				
Composite:				165.00				165.00				
MODA Incentive												-
Employer	97.00	196.00	137.00	235.00	97.00	196.00	137.00	235.00	78.00	155.00	111.00	188.00
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	97.00	196.00	137.00	235.00	97.00	196.00	137.00	235.00	78.00	155.00	111.00	188.00
Composite:				181.00				181.00				153.00
MODA 50%												
Employer	109.77	216.68	149.92	259.84	173.00	206.00	185.00	219.00				
Employee Cash Back	(48.00)	(94.00)	(65.00)	(113.00)	(87.00)	(87.00)	(87.00)	(87.00)				
FICA/PERS	(28.77)	(56.68)	(39.92)	(67.84)	(53.00)	(53.00)	(53.00)	(53.00)				
	33.00	66.00	45.00	79.00	33.00	66.00	45.00	79.00				
Composite:				61.00				61.00				
Dental Opt Out												
Employer	77.77	151.68	105.92	181.84	141.00	141.00	141.00	141.00	141.00	141.00	141.00	141.00
Employee Cash Back	(49.00)	(95.00)	(66.00)	(114.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)
FICA/PERS	(28.77)	(56.68)	(39.92)	(67.84)	(53.00)	(53.00)	(53.00)	(53.00)	(53.00)	(53.00)	(53.00)	(53.00)
EAP												
Employer Paid	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66
WELLNESS												
Employer Paid	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86

	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LIFE INSURANCE										
Face Value	$ 150,000	$ 150,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 75,000	$ 50,000	$ 50,000	$ 75,000
Employer Paid Premium	$22.20	$22.20	$6.80	$6.80	$6.80	$6.80	$10.20	$6.80	$6.80	$10.20
Face Value (Opt Down Coverage)	$ 50,000	$ 50,000								
Employer Premium	$22.85	$22.85								
Employee Cash Back	$ (11.00)	$ (11.00)								
FICA/PERS	$ (4.45)	$ (4.45)								
Premium	$ 7.40	$ 7.40								
$5000 Dependent - Employee Paid	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	
$2000 Dependent - Employer Paid										$0.38
AD&D - Employee - Employee Paid	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040
AD&D - Employee/Family - Employee Paid	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060
DISABILITY										
Short-Term Buy-Up Rate per $100 Salary	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24
Long-Term Buy-Up Rate per $100 Salary	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34
Maximum Covered Salary	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333
Employee Paid Buy-Up Max Salary	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 10,000
DEFERRED COMPENSATION										
Employer Paid	6.27%						1.00%	1-3% Match	1-3% Match	4.00%
PERS/OPSRP PENSION										
Employee Rate - County Paid	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
Employer Rate - PERS Tier 1 & 2	26.81%	22.24%	26.81%	22.24%	26.81%	26.81%	26.81%	26.81%	26.81%	26.81%
OPSRP General Service	21.26%	17.54%	21.26%	17.54%	21.26%	21.26%	21.26%	21.26%	21.26%	21.26%
OPSRP Police & Fire	25.62%						25.62%			25.62%
FICA										
Social Security	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%
Medicare	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%
RETIREE MEDICAL FUND										
Employer Paid - % of Base Salary	3.50%	(Sheriff's Office Employees Only - POA Union)								
	3.50%	(Sheriff's Office Employees Only - Command)								

	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LONGEVITY										
5 - 9 Years	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	$ 70.33
10-14 Years	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	$ 140.65
15-19 Years	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	$ 210.98
20-24 Years	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	$ 281.31
25-30 Years	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.0%	3.0%	$ 351.63
30+ Years	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.5%	3.5%	$ 421.96
VACATION ACCRUALS (MONTHLY)**										
< 5 Years	12.7	12.7	8.7	8.7	8.7	8.7	8.7	10.7	19.1	11.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
5 - 9 Years	14.0	14.0	10.7	10.7	10.7	10.7	10.7	12.7	21.1	13.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
10-14 Years	16.0	16.0	12.7	12.7	12.7	12.7	12.7	14.7	23.1	15.7
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
15-19 Years	18.0	18.0	14.7	14.7	14.7	14.7	14.7	16.0	24.4	17.0
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
20+ Years	19.3	19.3	16.7	16.7	16.7	16.7	16.7	16.7	25.1	18.3
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	360
VACATION SELLBACK ACCRUALS (MONTHLY)**										
Accrual (all years of service)	16	16	12	12	12	12	12			
Annual Maximum Carryover	280	280	250	250	250	250	250			
SICK LEAVE										
Monthly accrual	8	8	8	8	8	8	8	8	8	8
No Maximum Carryover										
HOLIDAYS										
Regular	10	10	10	10	10	10	10	10	0	10
Personal (Floating Holiday)	1	1	1	1	1	1	2	1	0	2

Note: Elected Officials do not receive longevity pay, nor do they accrue vacation, sick leave or Personal Holidays.

**Employees hired prior to 01/01/01 have a choice between the regular Vacation plan and the Vacation Sell Back plan.
Employees hired on or after 01/01/01 are enrolled in the Vacation Sell Back plan (except CCOM & POA).
Employees may sell one week of vacation each calendar year as long as they have taken at least one week of vacation during that year.
CCOM Dispatch employees earn additional vacation time in lieu of most holidays.

MERCER

2022 Health and Welfare Benefit Plan Final Renewal Report

Clackamas County
December 2021

General County

welcome to brighter

Contents

1

Summary

The Clackamas County General County 2022 health and welfare benefit plans renewal decisions are outlined in this report.

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

PLAN	2021 BUDGET RATE	2022 RENEWAL	% INCREASE
Active / Retiree Medical*			
General County			
VALUE: Kaiser HMO Option 10/10/1500 $350 Deductible; Vision $250/12 months			
EE	$675.60	$704.76	4.3%
EE, SP	1,351.18	1,409.50	4.3%
EE, CH	1,216.06	1,268.56	4.3%
EE, FAM	2,026.78	2,114.26	4.3%
COMPOSITE	1,435.54	$1,501.90	4.6%
BASE: PHP Personal Option 20/20/3000 $1000 Common Deductible (includes VSP vision)			
EE	$777.00	$792.00	1.9%
EE, SP	1,554.00	1,584.00	1.9%
EE, CH	1,401.00	1,428.00	1.9%
EE, FAM	2,334.00	2,379.00	1.9%
COMPOSITE	1,651.00	$1,699.00	2.9%
BUY-UP: PHP Open Option 20/10/30/2500 $750 Common Deductible (includes VSP vision)			
EE	$857.00	$874.00	2.0%
EE, SP	1,713.00	1,746.00	1.9%
EE, CH	1,545.00	1,575.00	1.9%
EE, FAM	2,571.00	2,620.00	1.9%
COMPOSITE	2,011.00	$2,021.00	0.5%
Retiree / Temporary Medical			
PHP $1400 Deductible			
EE	$732.38	$745.56	1.8%
EE, SP	1,464.88	1,491.24	1.8%
EE, CH	1,318.30	1,342.02	1.8%
EE, FAM	2,197.18	2,236.72	1.8%
Kaiser $1400 Deductible - General County			
EE	$502.52	$534.24	6.3%
EE, SP	1,005.04	1,068.50	6.3%
EE, CH	904.54	961.64	6.3%
EE, FAM	1,507.66	1,602.84	6.3%
PHP Medicare Align			
General County	$351.90	$351.90	0.0%
Kaiser Medicare			
General County	$405.42	$407.22	0.4%

Vision (VSP) – Rates and Contributions combined with Medical

General County: VSP 12/12/12; $10/$30 copay; $175/$95 allowance			
EE	$6.72	$7.48	11.3%
EE, SP	13.38	14.90	11.4%
EE, CH	14.34	15.96	11.3%
EE, FAM	22.90	25.50	11.4%
COMPOSITE	$16.00	$18.00	12.5%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County

General County: Delta Dental Incentive			
EE	$96.00	$97.00	1.0%
EE, SP	194.00	196.00	1.0%
EE, CH	136.00	137.00	0.7%
EE, FAM	233.00	235.00	0.9%
COMPOSITE	$184.00	$181.00	-1.6%
General County: Delta Dental Constant (50%)			
EE	$33.00	$33.00	0.0%
EE, SP	65.00	66.00	1.5%
EE, CH	45.00	45.00	0.0%
EE, FAM	78.00	79.00	1.3%
COMPOSITE	$63.00	$61.00	-3.2%
General County: Delta Dental Preventive			
EE	$84.00	$85.00	1.2%
EE, SP	169.00	171.00	1.2%
EE, CH	121.00	122.00	0.8%
EE, FAM	207.00	209.00	1.0%
COMPOSITE	$166.00	$165.00	-0.6%
General County/POA: Kaiser			
EE	$104.10	$104.10	0.0%
EE, SP	206.10	206.10	0.0%
EE, CH	143.66	143.66	0.0%
EE, FAM	246.68	246.68	0.0%
COMPOSITE	$191.00	$192.00	0.5%

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

**Rates include the standard 2022 contract changes.*

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

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2022 projection for the Open and Personal Options called for an overall 1.8% increase for the General County.

The 2022 Providence ASO fees are shown below as per employee per month (PEPM). These fees will be guaranteed for 3 years.

Providence Health Plan Administrative Fees

	2022 PEPM
Medical Administration	$32.45
Pharmacy Administration	5.41
Alternative Care Administration	2.30
Case and Disease Management	9.37
Network Access Fee	8.11
Health Coaching – 12 Sessions	2.12
	$59.76

Stop Loss Administrative Fees – RGA

As a result of the stop loss marketing, the stop loss coverage will be moved from Voya to RGA. The 2022 specific stop loss fee is $132.99 per employee per month. The specific attachment point will remain $200,000.

Mercer's underwriting projection for the 2022 renewal is included in **Exhibit A** for reference.

General County

Oregon Essential Health Benefits are changing effective 1/1/2022. Dollar limits on chiropractic and acupuncture care are no longer allowed. The BRC has elected a 30 visit limit on acupuncture, chiropractic, and massage therapy. Limits are per type of care. There is no visit limit or dollar limit on naturopathic care, which falls under primary care.

Exhibit B contains the required 2022 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2022.

See **Exhibit C** for the Providence 2022 General County benefit summaries.

Retirees – General County

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

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

Open Option 25/30/50/3000 $1400 Common Deductible
The 2022 benefit summary is included in **Exhibit C**.

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)
There is no change to the 2022 premium rate for the Providence Medicare Align plan.

Medicare Align Plan

Medicare Align With Prescription Drug	$351.90

Exhibit B contains the standard 2022 contract changes for non-grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2022 early retiree benefit summaries.

Kaiser Permanente

General County

Kaiser rates are increasing 4.3% for the HMO plan and 6.3% for the $1,400 deductible plan.

General County

The original renewal increase for the HMO plan was 6.3%. The BRC elected to increase the deductible to $350 for individuals and $700 for families and the out-of-pocket maximum to $1,500 for individuals and $3,000 for families.

Due to the changes in Oregon's Essential Health Benefits the HMO plan and $1,400 deductible plan will both have naturopathic care under primary care ($10 copay, no visit limit), Chiropractic care changes to $10 copay with 20 visit limit, acupuncture changes to $10 copay and 12 visit limit, and Massage will have a $25 copay and 12 visit limit. Dollar limits are removed from those coverages.

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

Exhibit E contains the 2022 contract changes provided by Kaiser. The BRC accepted the proposed 2022 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2022 benefit summaries.

Retirees – General County

Early (pre-age 65) retirees are eligible for the active employee HMO plan. Early retirees and COBRA participants are offered an additional plan as well.

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

Exhibit E contains the 2022 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2022 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The County was in rate guarantee through December 2022, but plan changes elected by the BRC impacted rates. The new rates are effective 1/1/2022 through 12/31/2022. The plan changes being made are increasing retail frame and elective contact lens allowance to $175 (Costco equivalent $95, feature frame $195) and adding a vision therapy rider for a fully covered evaluation and 75% off approved therapy sessions up to $750 annually.

See **Exhibit G** for the 2022 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

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

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

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

Exhibit I contains the Delta administrative contract changes for 2022 for General County.

See **Exhibit J** for the 2022 Delta benefit summaries.

Underwriting

Mercer projected a 2022 combined funding increase of 1.0% for the 2022 self-insured dental plans. For 2022, the combined increase will apply to each dental plan. The underwriting calculation is provided in **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2020, through June 30, 2021. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2022 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed no increase to the 2021 premium rates.

Exhibit E contains the 2022 standard contract changes provided by Kaiser, which will be effective January 1, 2022. See **Exhibit F** for the Kaiser 2022 benefit summaries.

The 2022 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

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

A summary of the rates for the 2022 plan year are as follows:

General County

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

General County

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

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

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

Long Term Disability Insurance

The Standard

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

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

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

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

The benefits will remain unchanged for the 2022 plan year.

Fees and Premium Rates

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

The 2022 funding, premium, and fees are as follows:

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

Employee Assistance Plan

Cascade Centers

The fee for EAP services is in rate guarantee through the end of 2022:

Fee per Participant per Month	
Employee Assistance Program	$2.66

Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia) to provide administration for the FSA plans. The fee is $5.15 per participant per month. The renewal fee is in year two of a three year guarantee.

The 2022 fees are as follows:

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

Long Term Care Insurance

Unum

Unum insures the voluntary long term care (LTC) coverage for General County employees. There is a rate hold for the 2022 plan year.

3

Employee Contributions

General County

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

The County will pay 95% of the tiered premium rates for non-represented employees.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
NONREPRESENTED				
Providence Personal Option – Base				
Employer	$752.40	1,504.80	1,356.60	2,260.04
Employee	39.60	79.20	71.40	118.96
Providence Open Option – Buy-Up				
Employer	$830.30	1,658.70	1,496.24	2,489.00
Employee	43.70	87.30	78.76	131.00
Kaiser – Value				
Employer	$669.54	1,339.02	1,205.14	2,008.54
Employee	35.22	70.48	63.42	105.72
Medical Opt Out				
Cash Back	83.00	164.00	148.00	247.00
REPRESENTED				
Providence Personal Option – Base				
Employer	707.06	1,499.06	1,343.06	2,294.06
Employee	84.94	84.94	84.94	84.94
Providence Open Option – Buy-Up				
Employer	747.20	1,619.20	1,448.20	2,493.20
Employee	126.80	126.80	126.80	126.80
Kaiser – Value				
Employer	629.66	1,334.40	1,193.46	2,039.16
Employee	75.10	75.10	75.10	75.10
Medical Opt Out				
Cash Back	185.00	185.00	185.00	185.00

General County - Dental

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

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

4

Exhibits

- Exhibit A – Self-Funded Medical/Rx Underwriting (Providence Health Plan)
- Exhibit B – Providence Health Plan – 2022 Contract Changes
- Exhibit C – Providence Health Plan – 2022 Benefit Summaries
- Exhibit D – Kaiser Permanente Medical and Dental Underwriting
- Exhibit E – Kaiser Permanente – 2022 Contract Changes
- Exhibit F – Kaiser Permanente – 2022 Benefit Summaries
- Exhibit G – VSP – 2022 Benefit Summaries
- Exhibit H – Self-funded Dental Underwriting Calculation
- Exhibit I – Delta Dental of Oregon – 2022 Contract Changes
- Exhibit J – Delta Dental of Oregon – 2022 Benefit Summaries
- Exhibit K – Carrier Information – A.M. Best Score

EXHIBIT A

Self-Funded Medical/Rx Underwriting (Providence Health Plan)

Clackamas County - General County

Medical/Rx Projection for Jan 1, 2022 through Dec 31, 2022

		GC Combined
1	***Most Recent 12 Months Ending***	
2	Paid Claims Entered for Entire 12-Month Period	$16,449,253
3	Stop Loss Credit	(1,067,665)
4	Historical Benefit Changes Adjustment	1.000
5	COVID Adjustment	63,320
6	Adjusted Paid Claims During This Period	$15,444,908
7	Average Setback Lives During This Period	921
8	Adjusted Paid Claims per Employee per Month	$1,397.48
9	Annual Trend (5% Medical, 9.5% Rx)	5.9%
10	Number of Months of Trend	19
11	Extended Trend Factor	1.094
12	**Projected Claims per Employee per Month**	**$1,529.22**
13	Claims Fluctuation Margin (%)	3.0%
14	Future COVID Adjustment	0.9%
	Projected Claims per Employee per Month+Margin	**$1,589.06**
15		
16	**Fixed Expenses**	
17	Providence Administration Fees - PEPM (3-year guarantee)	$60.76
18	Stop Loss Premium - PEPM (Estimated 20% increase)	162.28
19	Rx Rebates	(48.25)
20	**Total Administration / Retention per Employee per Month**	**$174.79**
21	**Projected Total Cost per Employee per Month**	**$1,763.85**
22	**Current Budget, based on Current Rates**	**$1,732.18**
23	**Needed Increase**	**1.8%**

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

EXHIBIT B

Providence Health Plans – 2022 Contract Changes

0121 to 0122 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice, Connect

– FINAL 11/16/2021 –

PROVIDENCE Health Plan

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Category A: Benefit Changes – For all plan types, except as otherwise denoted								
Universal Newborn Nurse Home Visits	All Handbooks	Addition of newborn nurse home visiting services	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn, newly adopted children, and newly fostered children eligibility and enrollment. *****	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* Newborn nurse home visits.** *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. **Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns (if covered by this Plan), for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services. **PLEASE NOTE:** Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is eligible and properly enrolled under this Plan within the time frames outlined in section 8.2.4 regarding Newborn Eligibility and Enrollment. **IMPORTANT NOTE:** Maternity Services for a Member who is serving as a surrogate parent are covered,	Yes	Yes – OR state mandate only (ORS 743A.078 & ORS 433.301); no federal mandate	This change **only applies** to non-ERISA ASO governmental groups that are either required to or choose to follow state mandates. It is otherwise completely *optional* for traditional ERISA-subject ASO groups. Oregon SB 526 created a new requirement for fully insured plans offered in the state of Oregon (including non-ERISA ASO groups which are required or electively choose to follow state law) to offer and reimburse the cost of nurse home visit services for newborns (including foster and adoptive newborns if applicable) up to 6 months of age. This benefit is available only to Oregon families residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program operates. Member participation in the Program is strictly voluntary. The coverage must be provided without any cost-sharing, coinsurance, or deductible (except where prohibited for HSA plans). The services are offered through community-level systems of care for families of newborns. It includes between one and three nurse home visits to every family with a newborn beginning at about three weeks of age. Using a tested screening tool, a nurse measures newborn and maternal health and assesses strengths and needs to link the family to community resources.	☑ Yes ☐ No

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
				except to the extent that such services are payable under the surrogate parenting contract or agreement.				
			IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.					
Foster Children Eligibility	All Handbooks (unless Group already has explicit language in its current handbook re: foster children eligibility)	We are adding explicit language for Groups that currently cover or want to cover foster children under their plan	**8.2.4 Newborn Eligibility and Enrollment** A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children[, and Newly Fostered Children] Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient	**8.2.4 Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment** A newborn, newly adopted child, or newly fostered child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption or foster care as long as enrollment occurs within 60 days of the birth date or placement for adoption or foster care and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn,	Yes (Only for Groups who are newly adding foster children eligibility now)	No	This change **only applies** to ASO groups that currently cover or wish to start covering foster children as an eligible class of dependents under their plan. (This change does NOT apply to Groups that cover foster children and already have such language in their self-authored SPDs.) For purposes of clarity for members, PHP is recommending that explicit coverage language be added for all ASO groups that currently cover foster children under their plan. PHP is also recommending the adoption of this language for any ASO groups that wish to start covering foster children under their plans. **Note:** There is no requirement for self-funded plans to cover foster children. This change merely serves to explicitly call out such coverage for ASO groups who do offer such coverage.	☐ Yes ☑ No

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan. The "special enrollment period" shall be a period of 30 days and begins on the later of:	newly adopted children, and newly fostered children eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption or foster care by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn, newly adopted children, and newly fostered children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption or foster care; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan. The "special enrollment period" shall be a period of 30 days and begins on the later of:				

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			• the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption. ****• in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. 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[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;	• the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption or foster care. ****• in the case of a Dependent's adoption or placement for adoption or foster care, the date of such adoption or placement for adoption or foster care; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption or foster care who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. 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[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;				

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			c) A child placed for adoption with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or 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 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[or foster care]). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.	c) A child placed for adoption or foster care with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption or foster care means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child or foster care (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption or foster care). Upon any termination of such legal obligations the placement for adoption or foster care shall be deemed to have terminated.				
Fertility Preservation Services	All Handbooks	Adding coverage for fertility preservation when related to treatment of oncological conditions	N/A **4.14.8 Prescription Drug Exclusions** ***** 4. Drugs used for the treatment of fertility/infertility;	**4.12.19 Fertility Preservation Services** The Plan covers Fertility Preservation where treatment related to cancer conditions may cause irreversible infertility, as recommended by clinical evidence-based guidelines such as those of the National Comprehensive Cancer Network (NCCN) and as outlined in our medical policy. Covered Services include the following: • Office visits, counseling and procedures related to Fertility Preservation; • Retrieval and storage of eggs and sperm; • Drugs related to retrieval and storage of eggs and sperm for Fertility Preservation. Examples include medications used to stimulate the ovaries for oocyte (egg) retrieval. Infertility treatment, including in-vitro fertilization, is NOT covered as part of this benefit. ***** **4.14.8 Prescription Drug Exclusions** ***** 4. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility	Yes	No	For 2022, PHP has elected to cover fertility preservation when related to the treatment of oncologic conditions. This includes male and female fertility preservation, drugs related to egg collection, and collection and storage devices. We are deciding to cover fertility preservation in instances where members are made infertile as a side effect of receiving oncological treatment. **Note:** Acceptance is *optional*, however, PHP recommends adoption for provide a better benefit for certain cancer-afflicted members and to align with medical policy.	☑ Yes ☐ No

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	Edit to exclusions only applies to groups which do not cover infertility services at all		***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:** • All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility: ***** ○ All services and prescription drugs related to fertility preservation; ***** **15. DEFINITIONS** **** N/A	Preservation for oncological conditions as outlined in section 4.12.19; ***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:** • All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility, except as described in section 4.12.19: ***** ○ All services and prescription drugs related to Fertility Preservation; ***** **15. DEFINITIONS** **** **Fertility Preservation** Fertility Preservation means the retrieval and storage of sperm and eggs where treatment of cancer conditions may cause irreversible infertility, as determined by our medical policy.			Edit to exclusions only applies to groups which do not cover infertility services at all	
Gender Dysphoria benefit	All Handbooks (except HSA plans)	Adding definition for Gender Dysphoria Adding language to clarify the Gender Dysphoria benefit includes gender affirming services	**14. DEFINITIONS** **** N/A **** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider	**14. DEFINITIONS** **** **Gender Dysphoria** Gender dysphoria refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. **** **4.12.13 Gender Dysphoria** Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria as determined by our medical policy. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For	Yes	Yes WA state mandate only (WA SB 5313); no federal mandate	This WA state mandate is completely **optional** for all ASO groups, whether your self-funded plans are subject to ERISA or not. Adoption of this optional WA state mandate is expected to have an impact on a Group's claim expenses due to the expanded gender dysphoria benefit coverage to include all gender affirming services. In 2021, Washington state enacted the Gender Affirming Treatment Act (SB 5313) which prohibits WA fully insured plans from applying any categorical cosmetic or blanket exclusions to gender affirming treatment when prescribed as medically necessary. "Gender affirming treatment" means a service or product a provider prescribes to an individual to treat any condition related to the individual's	☑ Yes ☐ No

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			surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.	example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for ~~a list of~~ more information on services requiring Prior Authorization.			gender identity and is prescribed in accordance with generally accepted standards of care. Such treatment includes, but is not limited to, cosmetic services (e.g., facial feminization surgeries), other facial gender affirming treatment (e.g., tracheal shaves, hair electrolysis, or other care (e.g., mastectomies, breast reductions, and breast implants), or any combination of gender affirming procedures, including revisions to prior treatment. Although this is a WA state mandate, PHP has decided to extend this coverage to our Oregon fully insured plans for 2022 for the benefit of our transgender members. However, this change is fully optional for ASO groups (see red note at the top). There is currently no federal mandate for this coverage for self-funded plans.	
Travel transplant benefit	All Handbooks	Update to the Travel Transplant benefit to increase amounts for travel expenses, food, and lodging	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per Diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel Services are not covered for donors.)	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 per transplant benefit maximum for transportation, food and lodging. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $5,000 travel expenses per transplant benefit maximum. (Note: Travel Services are not covered for donors.)	Yes	No	For 2022, PHP Is enhancing the benefit for travel expenses related to transplant services from a $5,000 ***lifetime*** benefit maximum to a $5,000 ***per transplant*** benefit maximum, and a $150 per diem limit for food and lodging to a $300 per diem limit. **Note:** Acceptance is *optional*. However, PHP recommends adoption to provide a better benefit for members needing transplant services.	☑ Yes ☐ No

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Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
Colorectal Cancer Preventive Screening Services	All Handbooks	Updating coverage for Colorectal Cancer Screen Exams from age 50 and older to age 45 and older	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 50 and older include: **** For Members age 50 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 50: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 45 and older include: **** For Members age 45 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 45: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	Yes	Yes	Effective May 2021. the United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in adults aged 45 to 49 years. Before that time, the recommendation was beginning at age 50. This is already a covered ACA preventive service. The change is the age at which colorectal cancer screening exams are covered in full, from age 50 and up to now age 45 and up. All ACA-compliant plans must cover services for adults that have a rating of A or B in the current recommendations of the USPSTF, pursuant to ACA preventive care guidelines. This new preventive service requirement for adults aged 45-49 has a B rating.	
Chiropractic Manipulation and/or Acupuncture benefit	All benefit summaries	Removing dollar limits on these Oregon EHBs as required by ACA	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	Yes	Yes	This change **only applies** to ASO groups that: 1) selected Oregon as its EHB benchmark plan; 2) currently offer a chiropractic manipulation and/or acupuncture benefit; and 3) currently impose annual or lifetime dollar $$ limits on either or both of these benefits. (If you do not meet all 3 criteria above, this contract change does NOT apply to you.) For 2022, Oregon added chiropractic care and acupuncture as essential health benefits (EHBs). Per ACA regulations, self-funded plans are not required to cover any EHBs. But if they do, there can be no annual or lifetime $$ dollar limits	

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				* No handbook change required; change is to benefit summaries only			imposed on any EHBs the self-funded plan chooses to offer. [45 CFR § 147.126] For ASO groups that meet all of the red criteria above, any current annual or lifetime $$ dollar limits (in-network & out-of-network) on your chiropractic and/or acupuncture benefit must be **removed** from your benefit summaries for 2022. Visit limits remain permissible.	
Prescription drug manufactur-er discount and/or copay assistance programs	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating to prescription drug exclusion on manufacturer discounts and/or copay assistance programs	**4.14.1 Using Your Prescription Drug Benefit** ***** • The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.	**4.14.1 Using Your Prescription Drug Benefit** ***** • The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.	Yes	Yes	Benefit administration change for 2022 on how drug manufacturer discounts and copay assistance programs will apply towards a member's annual limits on cost-sharing. We cannot implement the current exclusion setup nor enforce the exclusion consistently. Under the Final Notice of Benefit and Payment Parameters for 2021, self-funded plans and health insurance issuers have the flexibility to determine whether to include or exclude drug manufacturer coupon amounts or other drug manufacturer direct assistance from an enrollee's annual limitation on cost sharing.	
Amphetami-ne use prescription drug exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing amphetamine use as a prescription drug exclusion	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	Yes	No	We currently do not have a way to enforce this policy and Pharmacy has decided to remove exclusion language and continue with utilization management of amphetamines use.	
Drugs use in treatment of drug induced fatigue exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing the prescription drug exclusion regarding drug-induced fatigue,	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: *****	Yes	No	PHP has decided to retire this exclusion at the recommendation of our medical directors. There are many factors contributing to fatigue and a blanket exclusion like the one we are removing may prevent some members from receiving the drugs they need. Prescriptions are subject to approval.	

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		general fatigue and idiopathic hypersomnia						
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Virtual Visits (Telehealth Services)	All Handbooks except Personal Option	Renaming Virtual Visits to Telehealth Services to clearly reflect how PHP and health industry refers to benefit	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** ➢ Some Services are covered only under your In-Network benefits: • Virtual Visits, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Virtual Visits (see section 4.3.2). ***** --- **4.3.2 Virtual Visits** The Plan provides coverage for Virtual Visits with In-Network Providers using secure internet technology: • Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release. • Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, earache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** • Some Services are covered only under your In-Network benefits: • Telehealth Services, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Telehealth Services (see section 4.3.2). ***** --- **4.3.2 Telehealth Services** Telehealth services are services delivered through a variety of web-based or telecommunication technologies. The plan covers Telehealth services, when medically necessary and generally accepted healthcare practices and standards determine they can be safely and effectively provided using web-based or telecommunication technologies. **4.3.2.1 On-Demand Virtual Visits** Visits using a dedicated branded, web-based platform (such as Providence ExpressCare Virtual) through a tablet, smartphone, or computer for same-day appointments with a healthcare provider. Benefits will apply, as shown in your Benefit Summary. **4.3.2.2 Office Visits Virtually** Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom. Benefits will apply, as shown in your Benefit Summary. **4.3.2.3 Telemedicine Services**	No	No	This change has no impact on member benefits. We are removing the term "Virtual Visits" since we do not use that term to describe these services anymore, and to reduce member confusion. The term "Virtual Visits" is replaced with the term "Telehealth Services," which is an industry standard. We are also revising language to more clearly describe how Telehealth benefits are administered.	
---	All Handbooks	--- Language changes to align with PHP's administration of benefit						

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			sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.	Telemedicine Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; • Is delivered through a two-way ~~video~~ communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedicine Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member or another health professional on a Member's behalf, who is at an originating site. ***** **4.3.4 Telephone visits** Plan covers scheduled audio-only Office Visits for ~~established~~ patients with an In-network Provider ***** **15. DEFINITIONS** The following are definitions of important capitalized terms used in this Member Handbook. ***** **Providence ExpressCare Virtual Visits** Providence ExpressCare Virtual Visits can be utilized for common conditions; such as sore throat, cough, or			Modifying a previously presented language change. We have replaced "Telemedical" with "Telemedicine" to conform with the industry standard language. Removing the word "video" since these services are also provided via audio-only communication.	

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				fever, etc. using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments. Virtual Visits are with In-Network Providers who are contracted with Providence Health Plan to provide Providence ExpressCare Virtual. Benefits will apply, as shown in your Benefit Summary. See section 4.3.2 for more details. *****				
		Telemedical Services moved above to section 4.3.2.3 and replaced with Telephone visits in section 4.3.4	***** **4.3.4 Telemedical Services** Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; and • Is delivered through a two-way video communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site. *****				Making a corrective edit to a previously presented change that removes the word "established" as it is not a requirement; new patients may also receive these services. This is not a change in benefits and is only a language change.	

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		Updating definitions based on changes above; Adding Providence ExpressCare Virtual Visits definition; Removing Virtual Visits definition as that term is no longer used in section 4.3.2	**15. DEFINITIONS** The following are definitions of important capitalized terms used in this Member Handbook. ***** **Virtual Visit** Virtual Visit means a visit with an In-Network Provider using secure internet technology: • Phone and Video Visit: Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2). • Web-direct Visit: Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, earache, sinus pain or UTI (see also section 4.3.2).					
Women's Health Care Services	Choice and Connect Handbooks	Adding language to call out that women can self-refer to a women's health care provider	**2.1 [PLAN NAME]** Your [Plan Name] allows you to receive Covered Services from your Medical Home provider or by specialists when referred by your Medical Home Provider through what is called your In-Network benefit. Your In-Network benefit also provides coverage for Services to other In-Network Providers when you access these providers through a Medical Home Referral.	**2.1 [PLAN NAME]** Your [Plan Name] allows you to receive Covered Services from your Medical Home provider or by specialists when referred by your Medical Home Provider through what is called your In-Network benefit. Your In-Network benefit also provides coverage for Services to other In-Network Providers when you access these providers through a Medical Home Referral. A	No	Yes	We are adding language to clarify that a woman can access a women's health care provider without a referral for any type of plan, as required by both federal ACA and state reproductive equity laws. This protects a woman's right to directly access certain health care practitioners for women's health care services.	

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	--- Personal Option, HSA and Option Advantage Handbooks --- All Handbooks		***** **3.2.1 Medical Home Primary Care Providers** A Medical Home Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Medical Home Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Medical Home Primary Care Provider. ***** --- **3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES** Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the services), physician	woman can directly access a Women's Health Care Provider without a referral from her designated Medical Home. ***** **3.2.1 Medical Home Primary Care Providers** A Medical Home Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Medical Home Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Medical Home Primary Care Provider. ***** --- **3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES** Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider without a referral. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers				

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			assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.	and naturopaths (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.				
Updating language on HSA Qualified status	HSA Qualified Handbooks	Adding clarification that HSA qualification means that it may be paired with an employer sponsored HSA and HSA status is not automatic with enrollment in the Health Plan Adding detail that plan is disqualified as an HSA Qualified plan if it is provided in conjunction with an HRA Adding reference to section 2.1 from HSA and HDHP definitions for	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan for use in connection with a Health Savings Account (HSA). ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. ***** **15. DEFINITIONS** ***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with an HSA.	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan (HDHP) for use in connection with a Health Savings Account (HSA). Your eligibility for this HDHP means that it may be paired with an employer-sponsored HSA. However, HSA-Qualified plan status is not automatic with enrollment in this HDHP alone. Additional steps are required to pair this Plan with an HSA. ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. This Plan is also disqualified as an HSA-Qualified plan if it is provided alongside a Health Reimbursement Account (HRA). ***** **15. DEFINITIONS** ***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. See section 2.1 for more information on HSAs. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with	No	No	PHP is adding information to HSA books to explicitly state that HSA plans that are coupled with a Health Reimbursement Account (HRA) disqualifies the plan as HSA Qualified.	

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		more information		an HSA. See section 2.1 for more information on HDHPs.				
Medical home selection language	Choice and Connect Handbooks	Addition of online resources for medical home selection and rearrangement of options	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Mail your completed form to: Providence Health Plan Attn: Customer Service PO Box 3125 Portland, OR 97208 • **Email:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. E-mail your completed form to medicalhomeselectionforms@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Fax your completed form to 503-574-8208.	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Online**: Visit myProvidence to log into your account and select a Medical Home for you or your family* • **Mail**: Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Mail your completed form to: Providence Health Plan Attn: Customer Service P.O. Box 4327 Portland, OR 97208-4327 • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Fax your completed form to 503-574-8208. *Adults age 18 and over must log into myProvidence separately to select their own medical homes.	No	No	PHP is updating the language on Medical Home selection to help members select their Medical Home more easily. We believe this improvement will decrease call volume and it will also improve consistency across materials.	
		Email option is removed as it is not guaranteed to be secure on the end of the sender						

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Removing list of services requiring prior authorization from handbooks	All Handbooks	Removing list of services requiring prior authorization and directing members to the list on our website	**3.5 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. • Anesthesia Care with Diagnostic Endoscopy; • All Travel Expense Reimbursement, as provided in section 3.6. • All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health, and Chemical Dependency, as provided in sections 4.10 and 4.10.3. • All Applied Behavior Analysis Services, as provided in section 4.10.2. • All Human Organ/Tissue Transplant Services, as provided in section 4.13. • All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6. • All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7. • All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1. • All Sleep Study Services, as provided in section 4.4.2. • Certain Home Health Care Services, as provided in section 4. 11.1. • Certain Hospice Care Services, as provided in section 4.11.2. • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.	**3.5 PRIOR AUTHORIZATION** ***** **Services requiring Prior Authorization:** • A comprehensive list of services and supplies that must be Prior Authorized is available by visiting our website at ProvidenceHealthPlan.com/PriorAuthorization. You may also contact Customer Service to inquire whether a service or supply requires Prior Authorization. You or your Provider should submit Prior Authorization requests by following the instructions on our website. We will not require Prior Authorization for services and supplies that by law do not require Prior Authorization, including Emergency Room services. ***** **4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential,	No	No	For 2022, PHP is removing the Prior Authorization (PA) list from all handbooks to eliminate the need to maintain and update this list in multiple sources and to reduce the risk of misalignment between these sources as the PA list changes over time. Going forward, our public-facing ProvLink site, which is fully accessible by all PHP members and providers, will become the single source of truth for our PA lists for our ASO groups.	

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			• Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. • All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6. • All Genetic Testing Services, as provided in section 4.12.1. • Certain Bariatric Surgery Services, as provided in section 4.12.17. • Certain medications, including certain immunizations, received in your Provider's office, as provided in sections 4.3.5 and 4.1.2. • Certain prescription drugs specified in our Formulary, as provided in section 4.14.1. • Certain infused or injected medications that are clinically indicated for administration by a health care professional. • Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.	day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for more information on services requiring Prior Authorization. *****				
		Removing references to specific services being specified in Prior Authorization section as we are removing the list from the Handbooks	***** **4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All	**15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will				

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			inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient	determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. More information about Prior Authorizations are shown in section 3.5. ***** **2.1 [PLAN NAME]** Your Medical Home will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers or without a Medical Home Referral, it is your responsibility to make sure the Services are Prior Authorized by Providence Health Plan before treatment is received.				
		Clarifying that "select" surgical procedures are covered, whereas before						

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	Choice and Connect Handbooks	language could be interpreted as ALL surgical procedures	facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization. ***** **15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.5. ***** **2.1 [PLAN NAME]** Your Medical Home will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers or without a Medical Home Referral, it is your responsibility to make sure the Services listed in section 3.5 are Prior Authorized by Providence Health Plan before treatment is received.					
Our Members wording	All Handbooks	Removing use of words "our Members"	**3.8 MEDICALLY NECESSARY SERVICES** We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as	**3.8 MEDICALLY NECESSARY SERVICES** We believe you are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section	No	No	Removing use of "our members" is a PHP marketing initiative. Changing here to stay consistent across all materials.	

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			defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.	15. Services that do not meet Medically Necessary criteria will not be covered.				
Adding eviCore PA language	Groups who use eviCore for Outpatient Rehabilitation PA managem-ent	Adding language that describes PHP uses eviCore for PA of physical therapy and occupational therapy services	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity.	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity. Providers make notifications for outpatient rehabilitation services through an authorizing agent. A notification is the initial request submitted to the authorizing agent to inform Providence Health Plan that you are starting physical therapy and/or occupational therapy services. The authorizing agent determines if the requests are approved or require medical necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab.	No	No	For ASO groups that currently use eviCore for Prior Authorization of physical therapy and occupational therapy services ONLY. If you do not use eviCore for this purpose, this change does NOT apply to you. We are adding language to state that we use an authorizing agent (eviCore) for PT and OT services, and also adding a link that directs to our website for more information about eviCore. Making a language edit to a previously presented change to clarify this process and specify eviCore as a delegate rather than a TPA.	
Genetic Testing and Counseling Services	All Handbooks	Addition of language to clarify that select genetic testing requires Prior Authorization	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature.	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Select genetic testing requires Prior Authorization, for more information see section 3.5.	No	No	Clarifying requirements for certain genetic testing services and directing to the handbook section for Prior Authorization	

0121 to 0122 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice, Connect

– FINAL 11/16/2021 –

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Brand name drug coverage	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating language to explain how brand name drugs may be excluded if a generic exists	**4.14.1 Using Your Prescription Drug Benefit** • If you or your physician chooses a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.	**4.14.1 Using Your Prescription Drug Benefit** • • If a generic equivalent exists or becomes available, or if the cost of a brand-name drug changes, the tier placement of the brand-name drug may change, may require Prior Authorization, or the brand-name drug may no longer be covered. Additionally, if you choose a brand-name drug when a generic is available, you will be required to pay for the difference in cost between the brand-name drug and the generic drug, and the difference in cost will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.	No	No	To provide more transparency in how drugs are currently covered and how they will be setup to process in 2022.	
Growth hormone language	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are moving the growth hormone language from prescription drug limitations to prescription drug exclusions	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** 5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults. ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 2. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 3. Medications, drugs or hormones prescribed to stimulate growth, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults;	No	No	The exclusions section is a more suitable section for this language	
Replacement medications	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Modifying language to explicitly state damaged medications are excluded	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost, stolen, or damaged medication;	No	No	To provide transparency on the exclusion of replacing damaged medications.	

0121 to 0122 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice, Connect

– FINAL 11/16/2021 –

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Blister or bubble repackaging	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Adding language regarding blister or bubble repackaging to prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 13. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication; 13. Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging for the place of service submitted;	No	No	To provide transparency on the exclusion of repackaged medications unless it is the pharmacy's standard packaging.	
Out-of-network pharmacy use	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are adding out-of-network pharmacy use to our prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and 22. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.	No	No	To provide transparency on direct member reimbursements and the use of out-of-network pharmacies unless in urgent/emergent situations	
Urgent PA response time	All handbooks	Aligning urgent PA response time language with PHP operational standards	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 72 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified	No	No	This change **only applies** to ASO groups with traditional ERISA-subject self-funded plans. It does **not** apply to any ASO groups with non-ERISA ASO governmental plans that are either required to or choose to follow state law. Minor language correction to accurately reflect our current and historical operational practice for urgent prior authorization requests. Operationally, PHP has always responded to	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.	within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.			urgent PA requests within the 72-hour time frame specified by ERISA for traditional ASO self-funded plans. No practical impact to members, no PA claim administration change; this is a corrective handbook language edit only.	
Coordination of Benefits with Medicare	All Handbooks	Adding language for Medicare disabled/ESRD patients	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day. • Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day. • Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and	No	No	We are adding a paragraph that explains that the Coordination with Medicare rules may not apply to disabled people under 65 and ESRD patients, and direct members to the Medicare.gov website for more information.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.	individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan. **Medicare disabled and end-stage renal disease (ESRD) patients**: The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare; please see the Medicare website, Medicare.gov, for more information.				
Section 7.2.4 External Review	All Handbooks	Bolding the sentence outlining the timeline for release of medical records in the event of an External Review, requires emphasis Per the recent updates to 743B.254 in HB 2046	**7.2.4 External Review** **** If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.	**7.2.4 External Review** **** **If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review.** The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.**	No	Yes	This change **only applies** to non-ERISA ASO governmental plans that are either required to or choose to follow state law. It does **not** apply to any ASO groups with traditional ERISA-subject self-funded plans.	

EXHIBIT C

Providence Health Plans – 2022 Benefit Summaries

Administered by PROVIDENCE Health Plan

Your Benefit Summary

Open Option Plan
Clackamas County Early Retirees, COBRA Participants & Temporary Employees

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
$25	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$3,000 per person $6,000 per family (2 or more)	$1,400 per person $2,800 per family (2 or more)

Important information about your plan

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

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

Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	50%✓
• Vision and hearing screenings for children under 18	Covered in full✓	50%✓
• Routine immunizations; shots	Covered in full✓	50%✓
• Colonoscopy (age 50 +)	Covered in full✓	50%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits	$25 / visit✓	50%✓
• Office visits to Alternative Care Provider	$25 / visit✓	50%✓
• Phone and video visits	$5 / visit✓	50%✓
• Providence ExpressCare Retail Health Clinics	$25 / visit✓	Not applicable
• Allergy shots; serums; injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Diagnostic Services		
• X-ray; lab services	30%✓	50%
• High-tech Imaging services (such as PET, CT, MRI)	30%✓	50%
• Sleep studies	30%✓	50%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$25 / visit✓	50%✓
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	30%	30%

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Hospital Services		
• Inpatient/Observation care	30%	50%
• Rehabilitative care (limited to 30 days per calendar year)	30%	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	30%	50%
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	30%	50%
• Temporomandibular joint (TMJ) service (Limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	30%	50%
• Chiropractic manipulation and acupuncture (up to $500 per calendar year)	$25 / visit*	Not covered
Maternity Services		
• Prenatal office visits	Covered in full✓	50%
• Delivery and postnatal services	$100 / delivery✓	50%
• Inpatient hospital/facility services	30%	50%
• Routine newborn nursery care	30%✓	50%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	30%	50%
• Diabetes supplies (lancets, test strips and needles)	30%✓	50%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	30%	50%
• Hearing aids (One per ear per every three calendar years)	30%	50%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	30%	50%
• Day treatment, intensive outpatient and partial hospitalization services	30%	50%
• Applied behavior analysis	30%	50%
• Outpatient provider office visits	$25 / visit✓	50%✓
Home Health and Hospice		
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓

* No deductible needs to be met prior to receiving this benefit. Copayment does not apply to out-of-pocket maximums.

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-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

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

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

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

Formulary
A 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.

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

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

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

Out-of-network
Refers to services you receive from a non-network 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.

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

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

Contact us

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: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711 :TTY).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با تماس 1-800-878-4445 (TTY: 711) می‌توانید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

Your Benefit Summary

Prescription Drug Plan

Clackamas County Early Retirees and COBRA Participants

Administered by PROVIDENCE Health Plan

Important information about your plan

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

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to our network of 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 (preferred and non-preferred)	$10	$30	N/A
Brand-name drug (preferred and non-preferred)	50%	50%	
Specialty drug	N/A	N/A	50%

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you request a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a great than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- 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 be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- 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 Summary Plan Description 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.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website. If a formulary exception is approved, your generic or brand-name cost share will apply.
- 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.

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

Brand-name drug / Preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

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

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 / Preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Generic or Preferred generic drugs. Generally your out-of-pocket costs will be less for Preferred 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. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

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.

Preventive drug
A generic or brand medication included on the formulary, and required to be covered at no cost per federal regulation.

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

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

Contact us
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: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary

Out-of-Area Dependent

Clackamas County - General County Employees

Administered by PROVIDENCE Health Plan

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

Important information about your plan

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

- Some services must be prior authorized by us or a penalty will apply. See your Member Handbook for a list of these services.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Benefit Highlights	You pay the following for covered services:
	Coinsurance
Preventive Care	
• Periodic health exams and well-baby care	Covered in full
• Routine immunizations; shots	Covered in full
• Colonoscopy (age 50 +)	Covered in full
• Gynecological exams (calendar year) and Pap tests	Covered in full
• Mammograms	Covered in full
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full
Physician / Provider Services	
• Office visits	20%
• Office visits to Alternative Care Provider	20%
• Phone and video visits	$5 / visit
• Providence ExpressCare Retail Health Clinics	20%
• Allergy shots, serums, infusions, and injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Diagnostic Services	
• X-ray; lab services	20%
• High-tech Imaging services (such as PET, CT, MRI)	20%
• Sleep studies	20%
Emergency and Urgent Services	
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Emergency medical transportation (air and/or ground)	20%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (limited to 30 days per calendar year)	20%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%
Outpatient Services	
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Colonoscopy (non-preventive)	20%
• Temporomandibular joint (TMJ) service (Limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	20%
• Chiropractic manipulation, acupuncture, and massage therapy (Limited to 30 visits per service per calendar year)	$25 / visit*

* Copayment does not apply to out-of-pocket maximums.

Benefit Highlights (continued)	Coinsurance
Maternity Services	
• Prenatal office visits	Covered in full
• Delivery and postnatal services	20%
• Inpatient hospital/facility services	20%
• Routine newborn nursery care	20%
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%
• Diabetes supplies (lancets, test strips and needles)	20%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year)	20%
• Hearing aids (One per ear per every three calendar years)	20%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient and residential services	20%
• Day treatment, intensive outpatient and partial hospitalization services	20%
• Applied behavior analysis	20%
• Outpatient provider office visits	20%
Home Health and Hospice	
• Home health care	20%
• Hospice care	Covered in full

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 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.

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

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

Out-of-network
Refers to health care professionals who do 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.

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

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-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
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All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با تماس 1-800-878-4445 (TTY: 711) بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

Administered by PROVIDENCE Health Plan

Your Benefit Summary

Option Advantage B Plan (Buy-Up Plan)
Prescription Drug Plan
Clackamas County - General County Employees

Important information about your plan

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

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to our network of 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 (preferred and non-preferred)	$15	$30	N/A
Brand-name drug (preferred and non-preferred)	$30	$60	
Specialty drug	N/A	N/A	$30

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you request a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a great than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- 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 be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- 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.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website. If a formulary exception is approved, your generic or brand-name cost share will apply.
- 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.

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

Brand-name drug / Preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

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

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 / Preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Generic or Preferred generic drugs. Generally your out-of-pocket costs will be less for Preferred 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. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

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.

Preventive drug
A generic or brand medication included on the formulary, and required to be covered at no cost per federal regulation.

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.

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www.ProvidenceHealthPlan.com/contactus

Administered by PROVIDENCE Health Plan

Your Benefit Summary

Open Option (Buy-Up Plan)

Clackamas County - General County Employees

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
$20	10% coinsurance (after deductible)	30% coinsurance (after deductible; UCR applies)	$2,500 per person $5,000 per family (2 or more)	$750 per person $1,500 per family (2 or more)

Important information about your plan

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

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

Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	30%✓
• Vision and hearing screenings for children under 18	Covered in full✓	30%✓
• Routine immunizations; shots	Covered in full✓	30%✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	30%✓
• Mammograms	Covered in full✓	30%
• Colonoscopy; sigmoidoscopy	Covered in full✓	30%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits	$20 / visit✓	30%✓
• Office visits to Alternative Care Provider	$20 / visit✓	30%✓
• Phone and video visits	$5 / visit✓	30%✓
• Providence ExpressCare Retail Health Clinics	$20 / visit✓	Not applicable
• Allergy shots, serums, infusions and injectable medications	10%	30%
• Inpatient hospital visits	10%	30%
• Surgery; anesthesia	10%	30%
Diagnostic Services		
• X-ray and lab services	Covered in full✓	30%
• High-tech imaging services (such as PET, CT or MRI)	Covered in full✓	30%
• Sleep studies	Covered in full✓	30%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$20 / visit✓	30%✓
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	10%	10%

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Hospital Services		
• Inpatient/Observation care	10%	30%
• Rehabilitative care (30 days per calendar year)	10%	30%
• Skilled nursing facility (60 days per calendar year)	10%	30%
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	10%	30%
• Temporomandibular joint (TMJ) service (Limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	$20 / visit✓	30%
• Chiropractic manipulation, acupuncture, and massage therapy (Limited to 30 visits per service per calendar year)	$20 / visit**	Not covered
Maternity Services		
• Prenatal care	Covered in full✓	30%
• Delivery and postnatal services	$150 / delivery✓	30%
• Inpatient hospital/facility services	10%	30%
• Routine newborn nursery care	10%✓	30%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	10%✓	30%
• Diabetes supplies (lancets, test strips and needles)	10%✓	30%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	10%✓	30%
• Hearing aids (One per ear per every three calendar years)	10%✓	30%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	10%	30%
• Day treatment, intensive outpatient and partial hospitalization services	10%	30%
• Applied behavior analysis	10%	30%
• Outpatient provider visits	$20 / visit✓	30%✓
Home Health and Hospice		
• Home health care	10%	30%
• Hospice care	Covered in full✓	Covered in full✓

* Your deductible(s) do not apply to purchases of diabetes supplies.
** No deductible needs to be met prior to receiving this benefit. Copayment does not apply to out-of-pocket maximums.

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-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

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

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

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

Formulary
A 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.

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

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

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

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

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

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

Contact us

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Attn: Non-discrimination Coordinator
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Portland, OR 97208-4158

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U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

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Language Access Information

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

Administered by PROVIDENCE Health Plan

Your Benefit Summary

Personal Option Plan (Base Plan)
Prescription Drug Plan
Clackamas County - General County Employees

Important information about your plan

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

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to our network of 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 (preferred and non-preferred)	$10	$20	N/A
Brand-name drug (preferred and non-preferred)	50% up to $200	50% up to $400	
Specialty drug	N/A	N/A	50% up to $200

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you request a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance up to $200. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a great than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- 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 be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- 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.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website. If a formulary exception is approved, your generic or brand-name cost share will apply.
- 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.

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

Brand-name drug / Preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

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

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 / Preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Generic or Preferred generic drugs. Generally your out-of-pocket costs will be less for Preferred 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. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

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.

Preventive drug
A generic or brand medication included on the formulary, and required to be covered at no cost per federal regulation.

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.

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Your Benefit Summary

Personal Option Plan (Base Plan)

Clackamas County - General County Employees

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
$20	20% coinsurance (after deductible)	$3,000 per person $6,000 per family (2 or more)	$1,000 per person $2,000 per family (2 or more)

Important information about your plan

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

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

Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services:
✓ No deductible needs to be met prior to receiving this service	Copay or Coinsurance (from in-network providers only)
Preventive Care	
• Periodic health exams and well-baby care	Covered in full✓
• Vision and hearing screenings for children under 18	Covered in full✓
• Routine immunizations; shots	Covered in full✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓
• Mammograms	Covered in full✓
• Colonoscopy; sigmoidoscopy	Covered in full✓
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓
Physician / Provider Services	
• Office visits	$20 / visit✓
• Office visits to Alternative Care Provider	$20 / visit✓
• Phone and video visits	$5 / visit✓
• Providence ExpressCare Retail Health Clinics	$20 / visit✓
• Allergy shots, serums, infusions and injectable medications	$20 / visit✓
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Diagnostic Services	
• X-ray and lab services	Covered in full✓
• High-tech imaging services (such as PET, CT or MRI)	Covered in full✓
• Sleep studies	10%✓
Emergency and Urgent Services	
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$20 / visit✓
• Emergency medical transportation (air and/or ground)	20%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (limited to 30 days per calendar year)	20%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%
Outpatient Services	
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (Limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	$20 / visit✓
• Chiropractic manipulation, acupuncture, and massage therapy (Limited to 30 visits per service per calendar year)	$20 / visit*

* No deductible needs to be met prior to receiving this benefit. Copayment does not apply to out-of-pocket maximums.

Benefit Highlights (continued)

	Copay or Coinsurance
Maternity Services	
• Prenatal care	Covered in full✓
• Delivery and postnatal services	$150 / delivery✓
• Inpatient hospital/facility services	20%
• Routine newborn nursery care	20%✓
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%✓
• Diabetes supplies (lancets, test strips and needles)	20%✓
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	20%✓
• Hearing aids (One per ear per every three calendar years)	20%✓
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient and residential services	20%
• Day treatment, intensive outpatient and partial hospitalization services	20%
• Applied behavior analysis	20%
• Outpatient provider visits	$20 / visit✓
Home Health and Hospice	
• Home health care	20%
• Hospice care	Covered in full✓

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

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

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

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

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

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

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    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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Attn: Non-discrimination Coordinator
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Portland, OR 97208-4158

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U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با تماس 1-800-878-4445 (TTY: 711) می‌باشد.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

EXHIBIT D

Kaiser Permanente Medical and Dental 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-Low Deductible
Quote Name: 1183 County Custom $250 Ded 070 KONX 20

Region: Northwest
Contract Period: 01/01/2022 - 12/31/2022
Report Period: Mar 2020 through Feb 2021

	Mar20-Feb21
Average Members:	2,359

Rating Month: March 2021
Rating Members: 1,911

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$11,325,566	$400.055
A2	- Pooling Credit	Pooling Point:$325,000			0	0.000
A3	+ Pooling Charge				176,371	6.230
A4	Claims Net of Pooling				$11,501,938	$406.285
A5	X Incurred Claims Adjustment			1.00388		
A6	X Demographic Change			1.00394		
A7	X Historical Benefit Change			0.998450		
A8	Adjusted Claims					$408.835
A9	X Trend Factor	Annual Trend: 13.34%		1.25814		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$514.372
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$982,965	$514.372
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$982,965	$514.372
D4	+ Retention		70,879	37.090
D5	+ Other Benefits		31,742	16.610
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal PCORI Fee		440	0.230
D9	+ Premium Tax		22,164	11.598
D10	+ Commission		0	0.000
D11	**Uncapped PMPM Premium Requirement**		**$1,108,189**	**$579.900**
E	**Capping**	**Increase**		
E1	In-Force Rate		$1,036,630	$542.454
E2	Premium Requirement without Changes and Underwriter Adjustment	6.73%	1,106,356	578.941
E3	Capping Rate	6.15%	1,100,411	575.830
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**6.33%**	**1,102,244**	**576.789**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**6.33%**	**1,102,244**	**576.789**
E7	Capping Adjustment		(5,945)	(3.111)

Exhibit B
Page: 70

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: 1183 County Custom $1400 Ded 059 KONX 2

Region: Northwest
Contract Period: 01/01/2022 - 12/31/2022
Report Period: Mar 2020 through Feb 2021

	Mar20-Feb21
Average Members:	2,359

Rating Month: March 2021
Rating Members: 29

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$11,325,566	$400.055
A2	- Pooling Credit	Pooling Point:$325,000			0	0.000
A3	+ Pooling Charge				176,371	6.230
A4	Claims Net of Pooling				$11,501,938	$406.285
A5	X Incurred Claims Adjustment			1.00388		
A6	X Demographic Change			1.00394		
A7	X Historical Benefit Change			0.686910		
A8	Adjusted Claims					$281.268
A9	X Trend Factor	Annual Trend: 13.34%		1.25814		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$353.874
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$10,262	$353.874
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$10,262	$353.874
D4	+ Retention		1,076	37.090
D5	+ Other Benefits		414	14.270
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal PCORI Fee		7	0.230
D9	+ Premium Tax		240	8.275
D10	+ Commission		0	0.000
D11	**Uncapped PMPM Premium Requirement**		**$11,998**	**$413.739**
E	**Capping**	**Increase**		
E1	In-Force Rate		$14,573	$502.520
E2	Premium Requirement without Changes and Underwriter Adjustment	(17.83%)	11,975	412.933
E3	Capping Rate	6.15%	15,470	533.439
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**6.31%**	**15,493**	**534.245**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**6.31%**	**15,493**	**534.245**
E7	Capping Adjustment		3,495	120.506

Exhibit B
Page: 71

EXHIBIT E

Kaiser Permanente – 2022 Contract Changes

Summary of 2021 to 2022 Oregon Plan Changes

The following changes were made to
large group standard plan designs for 2022.

What's new at Kaiser Permanente

Below are some highlights of changes over the last year.

Medical plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Alternative care	Alternative care benefits (acupuncture, chiropractic, naturopathic, and massage therapy) updated for 2022 plan year. See the alternative care benefit changes table below. Alternative care exclusions list updated for consistency and to remove exclusions that are not specific to alternative care providers and services and/or are addressed in general exclusions or in other benefit sections. Alternative care covered services descriptions in the benefit section of the *Evidence of Coverage (EOC)* and the riders are standardized.	Simplify benefits, offer easier access for members, and meet market needs with flexible offerings that allow group customers to select the cost and coverage that is right for their needs. The benefit changes also meet the new essential health benefits (EHBs) requirements in Oregon. Benefit description enhancement. Benefit description enhancement.
Bariatric surgery services	Updated the benefit description in the *EOC* to clarify that the benefit covers the surgery procedures **and** related pre-surgery and post-surgery and includes two key points about the criteria: services for clinically severe obesity in adults are covered; and the member must receive the surgical services at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). Members may contact Member Services to request our criteria and get a list of the approved surgical procedures covered when criteria are met.	Benefit description enhancement.
Gender-neutral language	Existing contract language that contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Heathy Resources	Added a new “Healthy Resources” section to OR *EOCs* to explain value-added programs and resources available to members.	In compliance with disclosure requirements under ORS 746.035 and ORS 746.045.
Improved provider definitions	Several provider definitions have been modified.	Standardization between OR and WA, and consistency across product types.
Insulin for treatment of diabetes	Limits the cost sharing for insulin for the treatment of diabetes to $75 for a 30-day supply and $225 for a 90-day supply. Coverage may not be subject to a deductible.	Benefit enhancement to comply with OR HB 2623. Aligns insulin treatment cost shares across both OR and WA.

Benefit	Summary of changes	Reason for change
Medical coverage of dental services for potential transplant recipients	Additional coverage in medical plans for members who are potential transplant recipients. Routine dental services necessary to ensure the oral cavity is clear of infection so the member can be placed on the transplant waitlist will be covered.	Expanded coverage to remove oral care barriers for transplant patients.
Outpatient prescription drugs — preventive drug tier	Modified prescription drug riders that include a preventive drug tier to include a more comprehensive description of what a preventive drug is and clarified that this drug tier does **not** include preventive drugs required under ACA.	Benefit clarification.
Provider networks to replace benefit tiers	Replaced references to benefit "tiers" with language that explains coverage in terms of provider networks, cost shares, and how to obtain services.	Simplified for improved readability and understanding.
Subrogation	Modified the *EOC* section that addresses other party liability to clarify the member's role in helping us recover amounts from a claim settlement, judgment, or award from a third party.	Clarification of member's role.
Telehealth	Enhanced descriptions of telehealth services in the OR *EOCs.* An additional section in the OR Benefit Summaries will show the cost share for various types of telehealth services.	Enhanced benefit description.
Transplant services	Revised benefit description in the *EOC* to make it clearer that both inpatient and outpatient services related to covered transplants are covered at the cost share applicable to the service/place of service.	Benefit description enhancement.
Transplant services	Removed transplant description in OR *EOC* benefit summary section. In addition, the revised *EOC* transplant services language provides better clarity on covered transplant services.	Benefit clarification.

Alternative care benefit changes

Service type	2021		2022	
	Physician-referred	Self-referred	Physician-referred	Self-referred
Acupuncture care	Specialty office visit cost share, 12-visit limit.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).
Chiropractic care	Specialty office visit cost share.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).
Massage therapy	Not applicable.	Rider offering.	Not applicable.	Rider offering.
Naturopathic care	Specialty office visit cost share.	Rider offering.	Not covered.	Included in base plans at the primary office visit cost share with no visit limit.

Dental benefit plan changes

Benefit	Summary of changes	Reason for change
Dental plans that include coverage for dental implants: modifying implant cleaning and maintenance benefits	We cover routine cleaning of the implant surfaces up to 2 visits per year; and implant maintenance, where the prosthesis is removed and reinserted, once every 2 years. We will cover dental implant maintenance regardless of whether a Kaiser Permanente provider placed the implant system.	Improve dental implant care.
Gender-neutral language	Existing contract language that contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Subrogation	Modified the *EOC* section that addresses other party liability to clarify the member's role in helping us recover amounts from a claim settlement, judgment, or award from a third party.	Clarification of member's role.

New ways we are providing quality, providing convenience, and serving our mission

Getting care from the comfort of home

Your employees can rest assured knowing they can continue to get the high-quality care they depend on for all their health care needs. For primary care, specialty care, and mental health services, they can connect with their care team with e-visits, video visits, or phone appointments. *

*When appropriate and available. These features apply to care you get at Kaiser Permanente facilities.

Self-care at your fingertips — at no additional cost to members

We offer 2 digital self-care apps, Calm and myStrength, at no additional cost to members to help support their mental health and emotional well-being. *

*Only available to Kaiser Permanente members with medical coverage. myStrength® is a wholly owned subsidiary of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc.

Finding funding opportunities to manage the uncertainty of the current economic environment

We recently launched the Resilience Compass, a website that helps diverse businesses and employers find the support resources they need to help them succeed, especially in these tough economic times.

Visit **resiliencecompass.org** to find resources on training, funding, discounts, and more.

Getting dental advice at home

Members can send photos and communicate with their dental team via email through kp.org and the Kaiser Permanente app.*

*When appropriate and available. To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.

Getting connected to an interpreter, made easier

Members can now call the interpretation services number on the back of their Kaiser Permanente ID card to go through a new flow that connects them directly with an interpreter.

Bringing healing home with virtual cardiac rehabilitation

Kaiser Permanente is home to Oregon's first virtual cardiac rehab program. In its first year, 87% of participants completed Kaiser Permanente's 8-week virtual rehab program using wearable technology, compared with a less than 50% national average completion rate for those attending in-person rehab programs. *

*Randal J. Thomas et al., "Home-Based Cardiac Rehabilitation: A Scientific Statement from the American Association of Cardiovascular and Pulmonary Rehabilitation, the American Heart Association, and the American College of Cardiology," *Circulation,* July 2, 2019, p. e69. pubmed.ncbi.nlm.nih.gov/31097258

Seeking tomorrow's cure, today

Our cancer team is at the forefront of clinical trials, testing immunotherapy and other treatments that give patients more options for leading-edge care. In fact, Kaiser Permanente is a part of one of the largest cancer clinical research groups in the country. *

*Kaiser Permanente Center for Health Research, research.kpchr.org/Research/Research-Areas/Cancer, accessed April 9, 2021.

Furthering our mission with community health

We help people experiencing health inequities address the clinical, genetic, social, economic, and environmental factors that affect their ability to thrive. In 2019 alone, we invested more than $3.4 billion in the community. *

*2019 Kaiser Permanente Community Health Snapshot, about.kaiserpermanente.org/content/dam/internet/kp/comms/community-health/kp-community-health-snapshot-2019.pdf.

Summary of 2021 to 2022 Oregon Plan Changes

The following changes were made to
large group standard plan designs for 2022.

What's new at Kaiser Permanente

Below are some highlights of changes over the last year.

A new total health care option — our Complete Suite™ portfolio, with NEW Dual Choice PPO™ and Virtual Complete™ plans

Complete Suite refers to our portfolio of health plans available to employer groups with 51–499 eligible employees.

Choose a traditional plan or pair with our new Dual Choice PPO plans. Get a single-carrier solution with network choices your employees want. This means streamlined benefit administration for you, and an expanded network for your employees.

Dual Choice PPO

Dual Choice PPO plans provide you with flexibility to **offer nationwide coverage to employees —** through access to Kaiser Permanente providers, First Choice Health providers, First Health Network providers, other direct-contract providers, or any licensed provider. These plans must be offered alongside a traditional, deductible, or HDHP plan.

Lower cost shares using an enhanced benefit — Some in-network providers, including Kaiser Permanente, have lower cost shares for primary care, urgent care, specialty care, and routine eye exam visits. This is referred to as an enhanced benefit.

Virtual Complete

New Virtual Complete plans are available for both deductible plans and Dual Choice PPO plans. Eight new plans offer members flexibility in how they choose to get care — **taking advantage of our many virtual care options at no additional cost,** while still having primary care access to in-person care whenever they need it.

Members can connect with their care team and specialists they've been referred to by video or phone for $0.* They can also have a **set number of in-person primary care visits with a copay before meeting their deductible.**

*When appropriate and available. These features are available when you get care from Kaiser Permanente.

Medical plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Alternative care	Alternative care benefits (acupuncture, chiropractic, naturopathic, and massage therapy) updated for 2022 plan year. See the alternative care benefit changes table below. Alternative care exclusions list updated for consistency and to remove exclusions that are not specific to alternative care providers and services and/or are addressed in general exclusions or in other benefit sections. Alternative care covered services descriptions in the benefit section of the Evidence of Coverage (EOC) and the riders are standardized.	To simplify benefits, offer easier access for members, and meet market needs with flexible offerings that allow group customers to select the cost and coverage that is right for their needs. The benefit changes also meet the new Essential Health Benefits (EHBs) requirements in Oregon. Benefit description enhancement Benefit description enhancement
Medical coverage of dental services for potential transplant recipients	Additional coverage in medical plans for members who are potential transplant recipients. Routine dental services necessary to ensure the oral cavity is clear of infection so the member can be placed on the transplant waitlist will be covered.	Expanded coverage to remove oral care barriers for transplant patients.
Insulin for treatment of diabetes	Limits the cost sharing for insulin for the treatment of diabetes to $75 for a 30-day supply and $225 for a 90-day supply. Coverage may not be subject to a deductible.	Benefit enhancement to comply with OR HB 2623. Aligns insulin treatment cost shares across both OR & WA.
Provider networks to replace benefit tiers	Replaced references to benefit “tiers” with language that explains coverage in terms of provider networks, cost shares, and how to obtain services.	Simplified for improved readability and understanding.
Improved provider definitions	Several provider definitions have been modified.	Standardization between OR and WA, and consistency across product types.
Gender neutral language	Existing contract language which contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Bariatric Surgery Services	Updated the benefit description in the EOC to clarify that the benefit covers the surgery procedures **and** related pre-surgery and post-surgery and includes two key points about the criteria: services for clinically severe obesity in adults are covered; and the member must receive the surgical services at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality	Benefit description enhancement.

	Improvement Program (MBSAQIP). Members may contact Member Services to request our criteria and get a list of the approved surgical procedures covered when criteria is met.	
Transplant Services	Revised benefit description in the EOC to make it clearer that both inpatient and outpatient services related to covered transplants are covered at the cost share applicable to the service / place of service.	Benefit description enhancement.
Outpatient prescription drugs – preventive drug tier	Modified prescription drug riders that include a preventive drug tier to include a more comprehensive description of what a preventive drug is and clarified that this drug tier does not include preventive drugs required under ACA.	Benefit clarification.
Heathy Resources	Added a new "Healthy Resources" section to OR EOCs to explain value-added programs and resources available to members.	In compliance with disclosure requirements under OR law, ORS 746.035 and ORS 746.045
Telehealth	Enhanced descriptions of telehealth services in the OR EOCs. An additional section in the OR Benefit Summaries will show the cost share for various types of telehealth services.	Enhanced benefit description.
Transplant Services	Removed transplant description in OR EOC benefit summary section. In addition, the revised EOC transplant services language provides better clarity on covered transplant services.	Benefit clarification.
Subrogation	Modified the EOC section that addresses other party liability to clarify the member's role in assisting us to recover amounts from a claim settlement, judgement, or award from a third party.	Clarification of member's role.

Alternative care benefit changes

Service type	2021		2022	
	Physician-referred	Self-referred	Physician-referred	Self-referred
Acupuncture care	Specialty office cost share,12-visit limit.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).
Chiropractic care	Specialty office cost share.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).

Naturopathic care	Specialty office cost share.	Rider offering.	Now Under Primary Care.	Included in base plans at the primary office visit cost share with no visit limit.
Massage therapy	Not applicable.	Rider offering.	Not applicable.	Rider offering.

Deductible health plans

Summary of changes	Reason for change
Virtual Complete deductible plans can be offered alongside an aligned Dual Choice PPO offering.	Expand product offering.
In most cases, groups can keep their current plan except where noted.	Reduce marketed plans.

Plans affected	Changed from	Changed to
Virtual Complete deductible plans: DED PLAN VC 2500/40/20%/5500 DED PLAN VC 3000/40/30%/6000 DED PLAN VC 4000/50/30%/7000 DED PLAN VC 5000/50/40%/8000	Plans not offered.	Four new plans offered in Oregon.
DED PLAN AA 150/15/20%/1650 DED LGY 750/20/20%/2250 DED PLAN F 2000/25/20%/5500 DED PLAN J 4000/30/20%/7350 DED PLAN LGY 5000/30/20%/7350 DED PLAN K 5000/30/20%/7500 **All deductible value plans:** DED PLAN ValueNQ 30% DED PLAN ValueNQ 40% DED PLAN ValueNQ 50% And all related buy-ups	Plans offered.	Plans discontinued. Groups can keep their current plan. If there are any changes to benefits, the group should select a new plan. Please discuss your group's transition needs with your Kaiser Permanente account manager.

High deductible health plans (HSA-qualified)

Summary of changes		Reason for change
Maximum out-of-pocket adjustments to high deductible health plans.		Align with IRS maximums.
In most cases, groups can keep their current plan except where noted.		Reduce marketed plans.
Plans affected	**Changed from**	**Changed to**
All HDHP minimum value plans: HDHP PLAN LGY MV $3500 EE 50% HDHP PLAN MV $4500 EE 40% HDHP PLAN LGY MV $5500 EE 30% And all customized variations of these plans	Plans offered.	Plans discontinued. Groups currently on these plans will be asked to move to a new HDHP plan. Please discuss your group's transition needs with your Kaiser Permanente account manager.
HDHP PLAN $6900/0% HDHP PLAN AA 1400/10%/2800 HDHP PLAN AA 1400/20%/2800 HDHP PLAN A 1500/30%/2500 HDHP PLAN A 1500/10%/3500 HDHP PLAN A 1500/20%/3500 HDHP PLAN A 1500/30%/3500 HDHP PLAN B 2000/10%/4000 HDHP PLAN B 2000/50%/4000 HDHP PLAN C 2500/10%/5000 HDHP PLAN C 2500/50%/5000 HDHP PLAN D 2800/10%/4000 HDHP PLAN D 2800/20%/4000 HDHP PLAN D 2800/30%/4000 HDHP PLAN D 2800/40%/4000 HDHP PLAN D 2800/40%/5600 HDHP PLAN D 2800/50%/5600 HDHP PLAN E 3000/40%/6000 HDHP PLAN E 3000/50%/6000 HDHP PLAN F 3500/40%/6900 HDHP PLAN F 3500/50%/6900 HDHP PLAN G 4000/50%/6900 HDHP PLAN H 5000/50%/6900	Plan offered.	Plans discontinued. Groups can keep their current plan. Any change to benefits will require selecting a new plan from the Complete Suite offering.

HDHP PLAN A 1500/20%/3500	Individual maximum out-of-pocket: $2,500 Family maximum out-of-pocket: $5,000 Plan name: HDHP PLAN A 1500/20%/2500	Individual maximum out-of-pocket: $3,500 Family maximum out-of-pocket: $7,000 Plan name: HDHP PLAN A 1500/20%/3500
HDHP PLAN F 3500/20%/7000 HDHP PLAN F 3500/30%/7000 HDHP PLAN G 4000/20%/7000 HDHP PLAN G 4000/30%/7000 HDHP PLAN G 4000/40%/7000 HDHP PLAN H 5000/20%/7000 HDHP PLAN H 5000/30%/7000 HDHP PLAN H 5000/40%/7000 HDHP PLAN H 5000/50%/7000	Individual maximum out-of-pocket: $6,900 Family maximum out-of-pocket: $13,800 Plan name: Maximum out-of-pocket in plan name was $6,900.	Individual maximum out-of-pocket: $7,000 Family maximum out-of-pocket: $14,000 Plan name: Maximum out-of-pocket in plan name changed to $7,000. Groups can keep their current plan.

Dual Choice PPO™ plans

Summary of changes	Reason for change
Maximum out-of-pocket adjustments to high deductible health plans.	Comply with IRS change.
Dual Choice Virtual Complete plans added for pairing with standard deductible plans as part of the new Virtual Complete offering.	Expand product offering.
We're removing prior authorization requirements for outpatient rehabilitation therapies. Members will have direct access to physical therapy, occupational therapy, and speech therapy providers for both in and out-of-network providers. The therapist's office may still request a referral.	Improve member access to therapies.

Plans affected	Changed from	Changed to
Dual Choice PPO Virtual Complete deductible plans: PPO PLAN VC 2500/40/20%/6500 PPO PLAN VC 3000/40/30%/7000 PPO PLAN VC 4000/50/30%/8150 PPO PLAN VC 5000/50/40%/8150	Plans not offered.	Four new plans offered in Oregon.

PPO HDHP PLAN A 1500/20%/3500	In-network individual maximum out-of-pocket: $2,500 In-network family maximum out-of-pocket: $5,000 Out-of-network individual maximum out-of-pocket: $10,500 Out-of-network family maximum out-of-pocket: $21,000 Plan name: PPO HDHP PLAN A 1500/20%/2500	In-network individual maximum out-of-pocket: $3,500 In-network family maximum out-of-pocket: $7,000 Out-of-network individual maximum out-of-pocket: $11,500 Out-of-network family maximum out-of-pocket: $23,000 Plan name: PPO HDHP PLAN A 1500/20%/3500
PPO HDHP PLAN F 3500/20%/7000 PPO HDHP PLAN F 3500/30%/7000 PPO HDHP PLAN G 4000/20%/7000 PPO HDHP PLAN G 4000/30%/7000 PPO HDHP PLAN G 4000/40%/7000 PPO HDHP PLAN H 5000/20%/7000 PPO HDHP PLAN H 5000/30%/7000 PPO HDHP PLAN H 5000/40%/7000	Individual maximum out-of-pocket: $6,900 Family maximum out-of-pocket: $13,800 Plan name: Maximum out-of-pocket in plan name was $6,900.	Individual maximum out-of-pocket: $7,000 Family maximum out-of-pocket: $14,000 Plan name: Maximum out-of-pocket in plan name changed to $7,000. Groups can keep their current plan.

Added Choice® point-of-service plans

Summary of changes	Reason for change
New Dual Choice PPO offering is intended to replace Added Choice point-of-service plans.	Transition to Dual Choice.
We're removing prior authorization requirements for outpatient rehab therapies for services received from PPO and non-participating providers. Members will have direct access to physical therapy, occupational therapy, and speech therapy providers. The therapist's office may still request a referral.	Improve member access to therapies.

Plans affected	Changed from	Changed to

All Added Choice point-of-service plans	Plans offered to groups.	Product is being phased out. Groups currently on these plans will be asked to move to a new Dual Choice PPO plan within one renewal cycle. Please discuss your group's transition needs with your Kaiser Permanente account manager.
All Added Choice point-of-service deductible plans — renewals only	PPO network TMD benefit not subject to deductible.	PPO network TMD benefit subject to deductible.

Out-of-area PPO Plus® plans

Summary of changes		Reason for change
Out-of-area PPO Plus plans will continue to be offered alongside Dual Choice PPO plans for out-of-area members.		Continue out-of-area access.
Maximum out-of-pocket adjustments to high deductible health plans to better align with IRS changes and across aligned products.		Align with IRS changes.
We're removing prior authorization requirements for outpatient rehab therapies for services received from PPO and non-participating providers. Members will have direct access to physical therapy, occupational therapy, and speech therapy providers. The therapist's office may still request a referral.		Improve member access to therapies.
Plans affected	**Changed from**	**Changed to**
PPO PLUS HDHP AA PLAN WFI 1500/20%/3500	PPO network individual maximum out-of-pocket: $2,500 PPO network family maximum out-of-pocket: $5,000 Non-participating provider individual maximum out-of-pocket: $5,000 Non-participating provider family maximum out-of-pocket: $10,000 Plan name: PPO PLUS HDHP AA PLAN WFI 1500/20%/2500	PPO network individual maximum out-of-pocket: $3,500 PPO network family maximum out-of-pocket: $7,000 Non-participating provider individual maximum out-of-pocket: $6,000 Non-participating provider family maximum out-of-pocket: $12,000 Plan name: PPO PLUS HDHP AA PLAN WFI 1500/20%/3500

PPO PLUS HDHP AA PLAN WAS 2800/20%/4000	Non-participating provider individual maximum out-of-pocket: $5,000 Non-participating provider family maximum out-of-pocket: $10,000	Non-participating provider individual maximum out-of-pocket: $7,000 Non-participating provider family maximum out-of-pocket: $14,000

Dental benefit plan changes

Benefit	Summary of changes	Reason for change
Dental plans that include coverage for dental implants: modifying implant cleaning and maintenance benefits.	We cover routine cleaning of the implant surfaces up to 2 visits per year; and implant maintenance, where the prosthesis is removed and reinserted, once every 2 years. We will cover dental implant maintenance regardless of whether a Kaiser Permanente provider placed the implant system.	Improve dental implant care.
Gender neutral language	Existing contract language which contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Subrogation	The EOC section that addresses other party liability has been modified to clarify the member's role in assisting us to recover amounts from a claim settlement, judgement, or award from a third party. Additional edits to WA EOCs expressly providing that the member be made whole and to allow for accidents or injuries occurring in non-Made-Whole states.	Clarification of member's role. Benefit clarification

New ways we are providing quality, providing convenience, and serving our mission

Getting care from the comfort of home

Your employees can rest assured knowing they can continue to get the high-quality care they depend on for all their health care needs. For primary care, specialty care, and mental health services, they can connect with their care team with e-visits, video visits, or phone appointments.*

*When appropriate and available. These features apply to care you get at Kaiser Permanente facilities.

Self-care at your fingertips — at no additional cost to members

We offer 2 digital self-care apps, Calm and myStrength, at no additional cost to members to help support their mental health and emotional well-being.*

*Only available to Kaiser Permanente members with medical coverage. myStrength® is a wholly owned subsidiary of Livongo Health, Inc.

Finding funding opportunities to manage the uncertainty of the current economic environment

We recently launched the Resilience Compass, a website that helps diverse businesses and employers find the support resources they need to help them succeed, especially in these tough economic times.

Visit **resiliencecompass.org** to find resources on training, funding, discounts, and more.

Getting dental advice at home

Members can send photos and communicate with their dental team via email through kp.org and the Kaiser Permanente app.*

*When appropriate and available. To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.

Getting connected to an interpreter, made easier

Members can now call the interpretation services number on the back of their Kaiser Permanente ID card to go through a new flow that connects them directly with an interpreter.

Bringing healing home with virtual cardiac rehabilitation

Kaiser Permanente is home to Oregon's first virtual cardiac rehab program. In its first year, 87% of participants completed Kaiser Permanente's 8-week virtual rehab program using wearable technology, compared with a less than 50% national average completion rate for those attending in-person rehab programs.*

*Randal J. Thomas et al., "Home-Based Cardiac Rehabilitation: A Scientific Statement From the American Association of Cardiovascular and Pulmonary Rehabilitation, the American Heart Association, and the American College of Cardiology," *Circulation,* July 2, 2019, p. e69. pubmed.ncbi.nlm.nih.gov/31097258

Seeking tomorrow's cure, today

Our cancer team is at the forefront of clinical trials, testing immunotherapy and other treatments that give patients more options for leading-edge care. In fact, Kaiser Permanente is a part of one of the largest cancer clinical research groups in the country.*

*Kaiser Permanente Center for Health Research, research.kpchr.org/Research/Research-Areas/Cancer, accessed April 9, 2021.

Furthering our mission with community health

We help people experiencing health inequities address the clinical, genetic, social, economic, and environmental factors that affect their ability to thrive. In 2019 alone, we invested more than $3.4 billion in the community.*

*2019 Kaiser Permanente Community Health Snapshot, about.kaiserpermanente.org/content/dam/internet/kp/comms/community-health/kp-community-health-snapshot-2019.pdf.

EXHIBIT F

Kaiser Permanente – 2022 Benefit Summaries

Summary of Dental Benefits

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

Membership Services: 1-800-813-2000

Oregon R002 **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183-043**

Benefit Maximum per Calendar Year	None
	You pay
Dental Office Visit Charge – Per visit	$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 (Not subject to or counted toward the Deductible)	
Oral exam	$0
X-rays	$0
Teeth cleaning	$0
Fluoride	$0
Minor Restoration Services	
Routine fillings	$0
Plastic and steel crowns	$0
Simple extractions	$0
Oral Surgery Services	
Surgical tooth extractions	$0
Periodontics	
Treatment of gum disease	$0
Scaling and root planing	$0
Endodontics	
Root canal therapy	$0
Major Restoration Services	
Gold or porcelain crowns	$45
Bridges	$45
Removable Prosthetic Services	
Full upper and lower dentures	$65
Partial dentures	$95
Relines	$25
Rebases	$25
Nitrous oxide (Not subject to or counted toward the Deductible)	
Adults and children age 13 years and older	$25
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.
Implants	50% Coinsurance up to the $2,000 Dental Implant Benefit Maximum.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

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

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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Summary of Medical Benefits

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

Member Services: 1-800-813-2000

Oregon DED PLAN LGY 5000/30/20%/7350 **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183-070**

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible	
Self-only Deductible per Year (for a Family of one Member)	$350
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$350
Family Deductible per Year (for an entire Family)	$700
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$1,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$1,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	$3,000
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0
Primary Care	$10
Specialty Care	$10
Urgent Care	$10
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$0 per department visit
X-ray, imaging, and special diagnostic procedures	$0 per department visit
CT, MRI, PET scans	$0 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$10 generic / $20 brand
Mail Order Prescription drugs (up to a 90 day supply)	$20 generic / $40 brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$0
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	$0 per department visit
X-ray, imaging, and special diagnostic procedures	$0 per department visit
Inpatient Hospital Services	10% Coinsurance after Deductible

Hospital Services	**You pay**
Ambulance Services (per transport)	$75
Emergency services	$75 (Waived if admitted)
Inpatient Hospital Services	10% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Durable medical equipment	$0
Physical, speech, and occupational therapies (20 visits per therapy per Year)	$10
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	$0
Mental Health and Chemical Dependency Services	**You pay**
Outpatient Services	$10 per visit
Inpatient hospital & residential Services	10% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$10 per visit
Chiropractic Services (up to 20 visits per Year)	$10 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit
Naturopathic Medicine	$10 per visit
Vision Services	**You pay**
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	$10
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to $250 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once every Year.

[1] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to **http://www.kp.org/plandocuments**

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

This is not a contract. This condensed summary of benefits 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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Summary of Medical Benefits

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

Member Services: 1-800-813-2000

Oregon DED PLAN D 1000/25/20%/4000 **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183-059**

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible	
Self-only Deductible per Year (for a Family of one Member)	$1,400
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$1,400
Family Deductible per Year (for an entire Family)	$2,800
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$3,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$3,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$9,000
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0
Primary Care	$25
Specialty Care	20% Coinsurance after Deductible
Urgent Care	$25
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$20 generic / $40 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$40 generic / $80 preferred brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$5
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible

Hospital Services	**You pay**
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency services	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	20% Coinsurance
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible
Mental Health and Chemical Dependency Services	**You pay**
Outpatient Services	$25 per visit
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$10 per visit
Chiropractic Services (up to 20 visits per Year)	$10 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit
Naturopathic Medicine	$25 per visit
Vision Services	**You pay**
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	$25
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to $200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once in a two-Year period.

[1] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to **http://www.kp.org/plandocuments**

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

This is not a contract. This condensed summary of benefits 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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Kaiser Permanente Senior Advantage (HMO)
Summary of Medical Benefits Part D

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

Member Services: **1-877-221-8221** (TTY **711**)
8 a.m. to 8 p.m., 7 days a week

Oregon C22C **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183-042**

Deductible	
For one Member per Year	None
Out-of-Pocket Maximum[1]	
For one Member per Year	$600
Office visits	**You pay**
"Welcome to Medicare" preventive visit	$0
Primary Care	$10
Specialty Care[2†]	$10
Urgent Care	$10
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory[2†]	$0 per department visit
X-ray, imaging, and special diagnostic procedures[2†]	$0 per department visit
CT, MRI, PET scans[2†]	$0 per department visit
Medications (outpatient)	**You pay**

Prescription drugs†	$10 generic/$20 brand, for up to a 30-day supply, per prescription. When you get your drugs from our mail-order pharmacy, you may get up to a 31-90 day supply for two copayments. After you have paid $7,050 in true out-of-pocket costs for Part D covered drugs in a calendar year, you will pay the lesser of your copayment or $3 for generic drugs and $7 for brand drugs, per prescription.
Administered medications, including injections (all outpatient settings)†	$0
Nurse treatment room visits to receive injections†	$0
Hospital Services	**You pay**
Ambulance Services (per transport)	$50
Emergency department visit	$50
Inpatient Hospital Services[2†]	$0
Outpatient Services (other)	**You pay**
Outpatient surgery visit[2†]	$10
Chemotherapy/radiation therapy visit[2†]	$10
Durable medical equipment†	$0
Physical, speech, and occupational therapies[2†]	$10
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services up to 100 days per Medicare Benefit Period[2†]	$0
Mental Health and Substance Abuse Services†	**You pay**
Outpatient Services	$10
Inpatient Services	No charge
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$10 per visit
Chiropractic Services (up to 20 visits per Year)	$10 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit
Naturopathic Medicine	$10 per visit
Vision Services	**You pay**
Routine eye exam	$10
Vision hardware and optical Services	Balance after $200 allowance to use toward the purchase price of eyewear once within a two-calendar-year period.

Outside Service Area Benefit	20%. The annual benefit maximum is $1,250. Kaiser Permanente pays 80% up to $1,000 per year. You pay 100% thereafter. (In the U.S. only.)
Silver&Fit®	$0 for basic fitness center membership at participating centers.
Hearing Aids[2]	Balance after $1,500 allowance is applied for each hearing aid per ear every three years

[1] Refer to your Medical Benefits Chart for cost-sharing that does not apply to the out-of-pocket maximum.
[2] Your plan provider may need to provide a referral.
† Prior authorization may be required.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

Have questions?

- Please call Member Services at **1-877-221-8221 (**TTY **711**).
- 7 days a week, 8 a.m. to 8 p.m.

The benefit information provided is a brief summary, not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. If you receive Extra Help to pay for Medicare Part D prescription drug coverage, premiums and cost sharing will vary based on the level of Extra Help you receive. Please contact the plan for further details.

EXHIBIT G

VSP – 2022 Benefit Summaries

A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM CLACKAMAS COUNTY (GENERAL COUNTY) AND VSP.

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

vsp Vision care for life

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

PREMIER PROGRAM

Like shopping online? Go to **eyeconic.com** and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

\+ UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Exhibit B
Page: 102

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY
CLACKAMAS COUNTY (GENERAL COUNTY) and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2022

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Not all independent doctors in retail chains are participating providers. Please check before making an appointment.	$10	Every calendar year
PRESCRIPTION GLASSES			
FRAME	• $195 featured frame brands allowance • $175 frame allowance • 20% savings on the amount over your allowance; does not apply at retail chains • $95 Costco® frame allowance	$0	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	$0	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $30 $30	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $175 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
VISION THERAPY	• You get a fully covered evaluation and 75% off approved therapy sessions up to $750 annually. Sessions cover diagnosis and treatment of turned eye, eye teaming, lazy eye, eye focusing, and general eye movement ability. Check with your doctor to see if you qualify.		
PRIMARY EYECARE	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities •		
YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS			
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.			

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

All Active, COBRA, Retirees and dependents use their employee ID, which is 2-5 digits long and add zeroes in front to make it a 9-digit# as your VSP ID#.

Exhibit B
Page: 103

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

EXHIBIT H

Self-Funded Dental Plan Underwriting Calculation

Clackamas County - General County

Dental Projection for Jan 1, 2022 through Dec 31, 2022

	Incentive	Constant (50%)	Preventive	Combined
Most Recent 12 Months Ending		***June 30, 2021***		
Paid Claims for Entire 12-Month Period	$771,427	$49,993	$785,528	$1,606,948
Stop Loss Credit	0	0	0	0
Historical Benefit Changes Adjustment	1.000	1.000	1.000	1.000
COVID Adjustment	$29,661	$2,242	$29,799	$61,702
Adjusted Paid Claims During This Period	$801,088	$52,235	$815,327	$1,668,650
Average Enrollment Setback Lives During This Period	458	61	451	970
Adjusted Paid Claims per Employee per Month	$145.76	$71.36	$150.65	$143.35
Annual Trend	5.0%	5.0%	5.0%	5.0%
Number of Months of Trend	19	19	19	19
Extended Trend Factor	1.080	1.080	1.080	1.080
Projected Claims PEPM	**$157.46**	**$77.09**	**$162.75**	**$155.27**
Claims Fluctuation Margin	3.0%	3.0%	3.0%	3.0%
Projected Claims PEPM with Margin	**$162.19**	**$79.40**	**$167.63**	**$159.93**
Moda Administration Fee (1% increase)	$6.69	$6.69	$6.69	$6.69
Projected Total Cost PEPM	**$168.88**	**$86.09**	**$174.32**	**$166.62**
Current Budget, based on Current Rates	$179.59	$60.21	$163.78	$164.93
Needed Increase	**-6.0%**	**43.0%**	**6.4%**	**1.0%**

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

EXHIBIT I

Delta Dental of Oregon – 2022 Contract Changes

Clackamas County
Oregon ASO Dental Plan Changes
Renewing January 1, 2022
(Preliminary draft as of (3/23/2021)

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2022. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
Additional changes may be required as a result of new federal rules or regulations	We will monitor for any changes to the ACA.		TBD

STATE REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
2021 Legislative Session	We will monitor the Oregon legislative session for any new requirements that could apply.	To be determined	TBD

ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Pronoun changes	Removed binary pronouns. Replaced with either no pronoun (“the member,” “the person,” etc.) or they/their/them, to update language for gender-neutral inclusivity.

ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Benefits & Limitations	Added placement of device to facilitate eruption of impacted tooth.	This is not a benefit change. This service is currently covered as an orthodontia service and applies to the ortho lifetime maximum, but is not referenced in the handbook
Benefits and Limitations Restorative services - Basic	Added language that the plan denies post and core in addition to a crown unless less than half the coronal tooth structure remains.	Clarify existing limitation on post and core.
Enrolling Eligible Employees	Removed "Eligible employees can apply on the date of hire or the end of any required waiting period."	Unnecessary language
COBRA	Extending the length of COBRA coverage in the event of a disability	Updated language to clarify disability extension; disability must have started before the 61st day of the COBRA coverage period and the Social Security Administration determination must be made before the end of the initial 18-month COBRA coverage period

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

*Based on Delta Dental book of business.

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

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

Signature_____ **Date** 11/23/21

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

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If you need any of the above, call Customer Service at:

888-217-2365 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

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Delta Dental of Oregon & Alaska

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CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

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주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

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અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

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ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

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UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

EXHIBIT J

Delta Dental of Oregon – 2022 Benefit Summaries

2022 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

Clackamas County

Effective January 1, 2022

General County - Constant Plan	
Calendar year costs	
Calendar year maximum, per member (Class II, III & IV)	$2,000
Calendar year deductible, per member	$0
Class I* (Services do not apply to the calendar year max)	
Periodic examinations / X-rays	50%
Prophylaxis (cleanings) / periodontal maintenance	
Sealants	
Space maintainers	
Topical application of fluoride	
Class II	
Restorative fillings	50%
Oral surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
Class III	
Crowns and other cast restorations	50%
Class IV	
Implants	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	
Athletic mouthguard	
Nightguards - occlusal guard	100% to a $250 maximum (deductible waived)

* Deductible waived for preventive services.

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

How to use this dental plan

When you visit your dental provider, tell them you are a Delta Dental member.

When the member visits:

Delta Dental Premier Dentist:

Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:

Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class I services)

- **Diagnostic** Routine or comprehensive examinations or consultations are covered twice per year. Supplementary bitewing x-rays are covered twice per year. Complete series x-rays or a panoramic film are covered once in any 3-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance are covered once twice per year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per year for members under age 19. For members age 19 and older, topical application of fluoride is covered twice per year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class II services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Restorative If a tooth can be restored with a material such as amalgam or composite filling, but another type of restoration is selected, covered expense will be limited to a composite. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.
- **Periodontic** Scaling and root planing is limited to once every 6 months.
- **Miscellaneous** Oral sedatives are available to eligible dependents through age 17. Nitrous oxide shall be a covered benefit for members age 18 and over.

Major (Class III & IV services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Restorative** Cast restorations (including pontics) are covered once in a five (5) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a five (5) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past five (5) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Athletic mouthguard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 2-year period age 16 and over. Over-the-counter athletic mouthguards are excluded.
- **Occlusal Guard** (nightguard) covered at 100% once in a five year period, up to $250 maximum. Over-the-counter nightguards are excluded.

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 (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), 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 the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (except as provided under Class II, Miscellaneous) 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 a dental office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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Fax: 503-412-4003

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Portland, OR 97204
855-232-9111
compliance@modahealth.com

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and Human Services
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HHH Building, Washington, DC 20201

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Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 0569 (8/20)

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2022 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

Clackamas County

Effective January 1, 2022

General County - Incentive Plan

Calendar year costs	
Calendar year maximum, per member (Class II, III & IV)	$2,000
Calendar year deductible, per member	$0
Class I (Services do not apply to the calendar year max)	
Periodic examinations / x-rays	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Prophylaxis (cleanings) / periodontal maintenance	
Sealants	
Space maintainers	
Topical application of fluoride	
Class II	
Restorative fillings	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Oral surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
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Crowns and other cast restorations	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Class IV	
Implants	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	
Athletic mouthguard	
Nightguards - occlusal guard	100% to a $250 maximum (deductible waived)
Orthodontia	
Lifetime maximum of $2,000 (Child Benefit)**	50%

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

**See your member handbook for specific orthodontia benefits.

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- **Implants** and implant removal are limited to once per lifetime per tooth space.
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- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
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2022 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

Clackamas County

Effective January 1, 2022

General County - Preventive Plan	
Calendar year costs	
Calendar year maximum, per member (Class II, III & IV)	$2,000
Calendar year deductible, per member	$50
Calendar year maximum deductible, per family	$100
Class I (Services do not apply to the calendar year max)	
Periodic examinations / X-rays	100%
Prophylaxis (cleanings) / periodontal maintenance	
Sealants	
Space maintainers	
Topical application of fluoride	
Class II	
Restorative fillings	80%
Oral surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
Class III	
Cast restorations	80%
Crowns	70%
Class IV	
Implants	70%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	
Athletic mouthguard	
Nightguards - occlusal guard	100% to a $250 maximum (deductible waived)
Orthodontia	
Lifetime maximum of $3,000**	50%

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EXHIBIT K

Carrier Information – A.M. Best Score

Insurance Company	A.M. Best Carrier #	A.M. Best FSR and, where applicable, FSR Modifier	A.M. Best FSR Effective Date
Kaiser Foundation Health Plan of the Northwest	N/A	Not Rated	N/A
Providence Health Plan	N/A	Not Rated	N/A
Vision Service Plan	064607	A-	05/14/2021
Oregon Dental Service	064364	B+u	10/08/2021
Unum Life Insurance Company of America	006256	A	06/10/2021
Metropolitan Life Insurance Company	006704	A+	12/17/2020
Standard Insurance Company	007069	A	11/04/2021
Cascade Centers	N/A	Not Insured	N/A
Navia	N/A	Not Insured	N/A
RGA Reinsurance Company	009080	A+	09/30/2021
HM Life Insurance Company	009063	A	09/17/2021
ReliaStar Life Insurance Company of New York	006157	A	01/14/2021

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

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2022 Health and Welfare Benefit Plan Final Renewal Report

Clackamas County
December 2021

Peace Officers Association

CONTENTS

1

Summary

The Clackamas County Peace Officers Association (POA) 2022 health and welfare benefit plans' renewal decisions are outlined in this report.

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

PLAN	2021 BUDGET RATE	2022 RENEWAL	% INCREASE
Active / Retiree Medical*			
POA			
Kaiser HMO Option			
EE	$689.88	$733.50	6.3%
EE, SP	1,379.76	1,467.00	6.3%
EE, CH	1,241.78	1,320.30	6.3%
EE, FAM	2,069.64	2,200.50	6.3%
COMPOSITE	$1,571.44	$1,672.98	6.3%
PHP Personal Option 15/0/1000 (Includes VSP Vision)			
EE	$805.00	$709.00	-11.9%
EE, SP	1,609.00	1,418.00	-11.9%
EE, CH	1,450.00	1,278.00	-11.9%
EE, FAM	2,417.00	2,130.00	-11.9%
COMPOSITE	$1,960.00	$1,695.00	-13.5%
PHP Open Option 10/0/20/2000 $50 Common Deductible (Includes VSP Vision)			
EE	$861.00	$759.00	-11.8%
EE, SP	1,720.00	1,516.00	-11.9%
EE, CH	1,551.00	1,367.00	-11.9%
EE, FAM	2,582.00	2,276.00	-11.9%
COMPOSITE	$2,086.00	$1,844.00	-11.6%
Retiree / Temporary Medical			
PHP $1400 Deductible			
EE	$732.38	$745.56	1.8%
EE, SP	1,464.88	1,491.24	1.8%
EE, CH	1,318.30	1,342.02	1.8%
EE, FAM	2,197.18	2,236.72	1.8%
Kaiser $1400 Deductible - POA			
EE	$502.52	$534.24	6.3%
EE, SP	1,005.04	1,068.50	6.3%
EE, CH	904.54	961.64	6.3%
EE, FAM	1,507.66	1,602.84	6.3%
PHP Medicare Align			
POA	$351.90	$351.90	0.0%
Kaiser Medicare			
POA	396.44	$398.24	0.5%

Vision (VSP) – Rates and Contributions combined with Medical

POA: VSP 12/24/24; $10 copay; $130 allowance			
EE	$3.74	$3.74	0.0%
EE, SP	7.50	7.50	0.0%
EE, CH	8.02	8.02	0.0%
EE, FAM	12.84	12.84	0.0%
COMPOSITE	$10.10	$10.08	-0.2%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County

POA: Delta Dental Incentive			
EE	$74.00	$78.00	5.4%
EE, SP	146.00	155.00	6.2%
EE, CH	105.00	111.00	5.7%
EE, FAM	177.00	188.00	6.2%
COMPOSITE	$150.00	$153.00	2.0%
General County/POA: Kaiser			
EE	$104.10	$104.10	0.0%
EE, SP	206.10	206.10	0.0%
EE, CH	143.66	143.66	0.0%
EE, FAM	246.68	246.68	0.0%
COMPOSITE	$191.00	$192.00	0.5%

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

**Rates include the standard 2022 contract changes.*

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

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2022 projection for the Open and Personal Options called for an overall 12.6% decrease for the POA.

The 2022 Providence ASO fees are shown below as per employee per month (PEPM).

Providence Health Plan Administrative Fees

	2022 PEPM
Medical Administration	$32.45
Pharmacy Administration	5.41
Alternative Care Administration	2.30
Case and Disease Management	9.37
Network Access Fee	8.11
Health Coaching – 12 Sessions	2.12
	$59.76

Stop Loss Administrative Fees – RGA

As a result of the stop loss marketing, the stop loss coverage will be moved from Voya to RGA. The 2022 specific stop loss fee is $132.99 per employee per month. The specific attachment point will remain $200,000.

The underwriting exhibits for Providence are shown in **Exhibit A.**

Peace Officers

The following plan changes are being made for 2022:

- Chiropractic annual dollar limit is being removed, a 30 visit limit is being put in place. This change does not impact grandfathered status.
- Coverage for acupuncture and massage therapy will be added and each will have a 30 visit limit.

- Naturopathic care has no dollar or visit limit, this now falls under primary care.

The standard 2022 contract changes summary for grandfathered plans in **Exhibit B** apply to the POA plans.

See **Exhibit C** for the Providence 2022 POA benefit summaries.

Retirees – Peace Officers

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

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

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)

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

Medicare Align Plan

Medicare Align With Prescription Drug	$351.90

Exhibit B contains the standard 2022 contract changes for grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2022 early retiree benefit summaries.

Kaiser Permanente

Peace Officers

Kaiser proposed a 6.3% increase to the 2021 premium rates.

POA

The following changes to the Kaiser plan are part of the Oregon Essential Health Benefit changes for 2022.

- Naturopath will fall under primary care coverage with no visit limit
- Chiropractic will have a 20 visit limit and no dollar limit
- Acupuncture will have a 12 visit limit and no dollar limit
- Massage will have a 12 visit limit and no dollar limit

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

Exhibit E contains the 2022 contract changes provided by Kaiser. The POA accepted the proposed 2022 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2022 benefit summaries.

Retirees – Peace Officers

Early (pre-age 65) retirees are eligible for the active employee HMO plan. Early retirees and COBRA participants are offered an additional plan as well.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. Premium rates increased by 0.5%.

Exhibit E contains the 2022 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2022 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The VSP plan is in the second year of a rate guarantee. The plan will next renew January 1, 2023. The rates are provided in section 1

See **Exhibit G** for the 2022 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

The Incentive Plan is available to all employees.

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

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

The POA elected the following dental plan change for the 2022 plan year:

1. Occlusal guards now covered at 100%, no deductible, up to $250. This aligns the POA plan with industry standard. Occlusal guards were not previously covered

Exhibit I contains the Delta administrative contract changes for 2022 for POA.

See **Exhibit J** for the 2022 Delta benefit summaries.

Underwriting

Mercer projected a 2022 funding increase of 6.0% to the 2021 self-insured dental plan. See **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2020, through June 30, 2021. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2022 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed no increase to the 2021 premium rates.

Exhibit E contains the 2022 standard contract changes provided by Kaiser, which will be effective January 1, 2022. See **Exhibit F** for the Kaiser 2022 benefit summaries.

The 2022 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. The rates are being held for 2022 and renew January 1, 2023.

A summary of the rates for the 2022 plan year are as follows:

Peace Officer Association

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

Long Term Disability Insurance

The Standard

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

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

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

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

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

The benefits will remain unchanged for the 2022 plan year.

Fees and Premium Rates

The current rates will be in effect through December 31, 2022.

The 2022 funding, premium, and fees are as follows:

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

Employee Assistance Plan

Cascade Centers

The 2022 fee for EAP services is as follows:

Fee per Participant per Month	
Employee Assistance Program	$2.66

Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia) to provide administration for the FSA plans. The fee remains $5.15 per participant per month. The renewal fee will be guaranteed for two more years.

The 2022 fees are as follows:

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

3

Employee Contributions

Peace Officers

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

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Providence Personal Option				
Employer	$624.26	$1,333.26	$1,193.26	$2,045.26
Employee	$84.74	$84.74	$84.74	$84.74
Providence Open Option				
Employer	$666.82	$1,423.82	$1,274.82	$2,183.82
Employee	$92.18	$92.18	$92.18	$92.18
Kaiser				
Employer	$733.50	$1,467.00	$1,320.30	$2,200.50
Employee	$0.00	$0.00	$0.00	$0.00
HRA VEBA				
Cash Back	$176.00	$176.00	$176.00	$176.00

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

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

4

Exhibits

- Exhibit A – Self-Funded Medical/Rx Underwriting (Providence Health Plan)
- Exhibit B – Proposed Providence Health Plan – 2021 Contract Changes
- Exhibit C – Providence Health Plan – 2021 Benefit Summaries
- Exhibit D – Kaiser Permanente Medical and Dental Underwriting
- Exhibit E – Kaiser Permanente – 2021 Contract Changes
- Exhibit F – Kaiser Permanente – 2021 Benefit Summaries
- Exhibit G – VSP – 2021 Benefit Summaries
- Exhibit H – Self-funded Dental Underwriting Calculation
- Exhibit I – Proposed Delta Dental of Oregon – 2021 Contract Changes
- Exhibit J – Delta Dental of Oregon – 2021 Benefit Summaries
- Exhibit K – Carrier Information – A.M. Best Score

EXHIBIT A

Self-Funded Medical/Rx Underwriting (Providence Health Plan)

Clackamas County - POA

Medical/Rx Projection for Jan 1, 2022 through Dec 31, 2022

		Open Option		Personal Option		POA Combined
1	***Most Recent 12 Months Ending***	***June 30, 2021***	***June 30, 2020***	***June 30, 2021***	***June 30, 2020***	
2	Paid Claims for Entire 12-Month Period	$4,171,739	$4,542,502	$858,503	$722,464	
3	Stop Loss Credit	(331,720)	(437,808)	0	0	
4	Historical Benefit Changes Adjustment	1.000	1.000	1.000	1.000	
5	COVID Adjustment	193,549	205,136	43,271	36,106	
6	Adjusted Paid Claims during This Period	$4,033,567	$4,309,830	$901,774	$758,569	
7	Average Setback Lives during This Period	252	261	86	77	
8	Adjusted Paid Claims per Employee per Month (PEPM)	$1,333.85	$1,376.06	$873.81	$820.96	
9	Annual Trend (5% Medical, 9.5% Rx)	6.4%	6.1%	5.5%	5.5%	
10	Number of Months of Trend	19	31	19	31	
11	Trend Factor	1.102	1.167	1.088	1.149	
12	**Projected Claims PEPM**	**$1,470.56**	**$1,605.38**	**$950.90**	**$943.45**	
	Blended Projected Claims PEPM (70%/30%)	**$1,511.01**		**$948.67**		**$1,373.07**
13	Claims Margin (%)	3.0%		3.0%		3.0%
14	Future COVID Adjustment	0.9%		0.9%		0.9%
15	**Projected Claims per Employee per Month+Margin**	**$1,570.14**		**$985.79**		**$1,426.80**
16	**Fixed Expenses**					
17	Providence Administration Fees - PEPM (3-year guarantee)	$60.76		$60.76		$60.76
18	Stop Loss Premium - PEPM (estimated 20% increase)	162.28		162.28		162.28
19	Rx Rebates	(56.39)		(56.39)		(56.39)
20	**Total Administration / Retention per Employee per Month**	**$166.65**		**$166.65**		**$166.65**
21	**Projected Total Cost per Employee per Month**	**$1,736.79**		**$1,152.44**		**$1,593.45**
22	**Current Budget, based on Current Rates**	**$1,852.91**		**$1,737.81**		**$1,822.53**
23	**Needed Increase**	**-6.3%**		**-33.7%**		**-12.6%**

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

EXHIBIT B

Providence Health Plans – 2022 Contract Changes

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) ASO grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Category A: Benefit Changes – For all plan types, except as otherwise denoted								
Universal Newborn Nurse Home Visits	All Handbooks	Addition of newborn nurse home visiting services	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn, newly adopted children, and newly fostered children eligibility and enrollment. *****	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* Newborn nurse home visits.** *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. **Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns (if covered by this Plan), for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services. **PLEASE NOTE:** Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is eligible and properly enrolled under this Plan within the time frames outlined in section 8.2.4 regarding Newborn Eligibility and Enrollment. **IMPORTANT NOTE:** Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.	Yes	Yes – OR state mandate only (ORS 743A.078 & ORS 433.301); no federal mandate	This change **only applies** to non-ERISA ASO governmental groups that are either required to or choose to follow state mandates. It is otherwise completely *optional* for traditional ERISA-subject ASO groups. Oregon SB 526 created a new requirement for fully insured plans offered in the state of Oregon (including non-ERISA ASO groups which are required or electively choose to follow state law) to offer and reimburse the cost of nurse home visit services for newborns (including foster and adoptive newborns if applicable) up to 6 months of age. This benefit is available only to Oregon families residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program operates. Member participation in the Program is strictly voluntary. The coverage must be provided without any cost-sharing, coinsurance, or deductible (except where prohibited for HSA plans). The services are offered through community-level systems of care for families of newborns. It includes between one and three nurse home visits to every family with a newborn beginning at about three weeks of age. Using a tested screening tool, a nurse measures newborn and maternal health and assesses strengths and needs to link the family to community resources.	☑ Yes ☐ No

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.					
Fertility Preservation Services	All Handbooks	Adding coverage for fertility preservation when related to treatment of oncological conditions	N/A	**4.12.19 Fertility Preservation Services** The Plan covers Fertility Preservation where treatment related to cancer conditions may cause irreversible infertility, as recommended by clinical evidence-based guidelines such as those of the National Comprehensive Cancer Network (NCCN) and as outlined in our medical policy. Covered Services include the following: • Office visits, counseling and procedures related to Fertility Preservation; • Retrieval and storage of eggs and sperm; • Drugs related to retrieval and storage of eggs and sperm for Fertility Preservation. Examples include medications used to stimulate the ovaries for oocyte (egg) retrieval. Infertility treatment, including in-vitro fertilization, is NOT covered as part of this benefit. *****	Yes	No	For 2022, PHP has elected to cover fertility preservation when related to the treatment of oncologic conditions. This includes male and female fertility preservation, drugs related to egg collection, and collection and storage devices. We are deciding to cover fertility preservation in instances where members are made infertile as a side effect of receiving oncological treatment. **Note:** Acceptance is *optional*, however, PHP recommends adoption for provide a better benefit for certain cancer-afflicted members and to align with medical policy.	☑ Yes ☐ No
			4.14.8 Prescription Drug Exclusions ***** 4. Drugs used for the treatment of fertility/infertility;	**4.14.8 Prescription Drug Exclusions** ***** 4. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility Preservation for oncological conditions as outlined in section 4.12.19;				
			***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:**	***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:**				

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
	Edit to exclusions only applies to groups which do not cover infertility services at all		• All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility: ***** ○ All services and prescription drugs related to fertility preservation; ***** **15. DEFINITIONS** **** N/A	• All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility, except as described in section 4.12.19: ***** ○ All services and prescription drugs related to Fertility Preservation; ***** **15. DEFINITIONS** **** **Fertility Preservation** Fertility Preservation means the retrieval and storage of sperm and eggs where treatment of cancer conditions may cause irreversible infertility, as determined by our medical policy.			Edit to exclusions only applies to groups which do not cover infertility services at all	
Gender Dysphoria benefit	All Handbooks (except HSA plans)	Adding definition for Gender Dysphoria Adding language to clarify the Gender Dysphoria benefit includes gender affirming services	**15. DEFINITIONS** **** N/A **** **4.12.10 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.	**15. DEFINITIONS** **** **Gender Dysphoria** Gender dysphoria refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. **** **4.12.10 Gender Dysphoria** Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria as determined by our medical policy. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for more information on services requiring Prior Authorization.	Yes	Yes WA state mandate only (WA SB 5313); no federal mandate	This WA state mandate is completely **optional** for all ASO groups, whether your self-funded plans are subject to ERISA or not. Adoption of this optional WA state mandate is expected to have an impact on a Group's claim expenses due to the expanded gender dysphoria benefit coverage to include all gender affirming services. In 2021, Washington state enacted the Gender Affirming Treatment Act (SB 5313) which prohibits WA fully insured plans from applying any categorical cosmetic or blanket exclusions to gender affirming treatment when prescribed as medically necessary. "Gender affirming treatment" means a service or product a provider prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Such treatment includes, but is not limited to, cosmetic services (e.g., facial feminization surgeries), other facial gender affirming treatment (e.g., tracheal shaves, hair electrolysis, or other care (e.g., mastectomies, breast reductions, and breast implants), or any	☑ Yes ☐ No

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
							combination of gender affirming procedures, including revisions to prior treatment. Although this is a WA state mandate, PHP has decided to extend this coverage to our Oregon fully insured plans for 2022 for the benefit of our transgender members. However, this change is fully optional for ASO groups (see red note at the top). There is currently no federal mandate for this coverage for self-funded plans.	
Foster Children Eligibility	All Handbooks (unless Group already has explicit language in its current handbook re: foster children eligibility)	We are adding explicit language for Groups that currently cover or want to cover foster children under their plan	**8.2.4 Newborn Eligibility and Enrollment** A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children[, and Newly Fostered Children] Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level	**8.2.4 Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment** A newborn, newly adopted child, or newly fostered child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption or foster care as long as enrollment occurs within 60 days of the birth date or placement for adoption or foster care and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits	Yes (Only for Groups who are newly adding foster children eligibility now)	No	This change **only applies** to ASO groups that currently cover or wish to start covering foster children as an eligible class of dependents under their plan. (This change does NOT apply to Groups that cover foster children and already have such language in their self-authored SPDs.) For purposes of clarity for members, PHP is recommending that explicit coverage language be added for all ASO groups that currently cover foster children under their plan. PHP is also recommending the adoption of this language for any ASO groups that wish to start covering foster children under their plans. **Note:** There is no requirement for self-funded plans to cover foster children. This change merely serves to explicitly call out such coverage for ASO groups who do offer such coverage.	☒ Yes ☐ No

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			shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.	made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn, newly adopted children, and newly fostered children eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption or foster care by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn, newly adopted children, and newly fostered children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption or foster care; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.				

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			The "special enrollment period" shall be a period of 30 days and begins on the later of: • the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption. ****• in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. 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[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;	The "special enrollment period" shall be a period of 30 days and begins on the later of: • the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption or foster care. ****• in the case of a Dependent's adoption or placement for adoption or foster care, the date of such adoption or placement for adoption or foster care; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption or foster care who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. 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[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;				

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			c) A child placed for adoption with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or 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 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[or foster care]). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.	c) A child placed for adoption or foster care with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption or foster care means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child or foster care (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption or foster care). Upon any termination of such legal obligations the placement for adoption or foster care shall be deemed to have terminated.				
Travel transplant benefit	All Handbooks	Update to the Travel Transplant benefit to increase amounts for travel expenses, food, and lodging	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per Diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel Services are not covered for donors.)	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 per transplant benefit maximum for transportation, food and lodging. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $5,000 travel expenses per transplant benefit maximum. (Note: Travel Services are not covered for donors.)	Yes	No	For 2022, PHP Is enhancing the benefit for travel expenses related to transplant services from a $5,000 ***lifetime*** benefit maximum to a $5,000 ***per transplant*** benefit maximum, and a $150 per diem limit for food and lodging to a $300 per diem limit. **Note:** Acceptance is *optional*. However, PHP recommends adoption to provide a better benefit for members needing transplant services.	☑ Yes ☐ No

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

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Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
Colorectal Cancer Preventive Screening Services	All Handbooks	Updating coverage for Colorectal Cancer Screen Exams from age 50 and older to age 45 and older	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 50 and older include: **** For Members age 50 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 50: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 45 and older include: **** For Members age 45 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 45: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	Yes	Yes	Effective May 2021. the United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in adults aged 45 to 49 years. Before that time, the recommendation was beginning at age 50. This is already a covered ACA preventive service. The change is the age at which colorectal cancer screening exams are covered in full, from age 50 and up to now age 45 and up. All ACA-compliant plans must cover services for adults that have a rating of A or B in the current recommendations of the USPSTF, pursuant to ACA preventive care guidelines. This new preventive service requirement for adults aged 45-49 has a B rating.	
Chiropractic Manipulation and/or Acupuncture benefit	All benefit summaries	Removing dollar limits on these Oregon EHBs as required by ACA	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license. * No handbook change required; change is to benefit summaries only	Yes	Yes	This change **only applies** to ASO groups that: 1) selected Oregon as its EHB benchmark plan; 2) currently offer a chiropractic manipulation and/or acupuncture benefit; and 3) currently impose annual or lifetime dollar $$ limits on either or both of these benefits. (If you do not meet all 3 criteria above, this contract change does NOT apply to you.) For 2022, Oregon added chiropractic care and acupuncture as essential health benefits (EHBs). Per ACA regulations, self-funded plans are not required to cover any EHBs. But if they do, there can be no annual or lifetime $$ dollar limits	

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							imposed on any EHBs the self-funded plan chooses to offer. [45 CFR § 147.126] For ASO groups that meet all of the red criteria above, any current annual or lifetime $$ dollar limits (in-network & out-of-network) on your chiropractic and/or acupuncture benefit must be **removed** from your benefit summaries for 2022. Visit limits remain permissible.	
Prescription drug manufactur-er discount and/or copay assistance programs	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating to prescription drug exclusion on manufacturer discounts and/or copay assistance programs	**4.14.1 Using Your Prescription Drug Benefit** ***** • The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.	**4.14.1 Using Your Prescription Drug Benefit** ***** • The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.	Yes	Yes	Benefit administration change for 2022 on how drug manufacturer discounts and copay assistance programs will apply towards a member's annual limits on cost-sharing. We cannot implement the current exclusion setup nor enforce the exclusion consistently. Under the Final Notice of Benefit and Payment Parameters for 2021, self-funded plans and health insurance issuers have the flexibility to determine whether to include or exclude drug manufacturer coupon amounts or other drug manufacturer direct assistance from an enrollee's annual limitation on cost sharing.	
Amphetami-ne use prescription drug exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing amphetamine use as a prescription drug exclusion	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	Yes	No	We currently do not have a way to enforce this policy and Pharmacy has decided to remove exclusion language and continue with utilization management of amphetamines use.	

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

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Drugs use in treatment of drug induced fatigue exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing the prescription drug exclusion regarding drug-induced fatigue, general fatigue and idiopathic hypersomnia	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 14.	Yes	No	PHP has decided to retire this exclusion at the recommendation of our medical directors. There are many factors contributing to fatigue and a blanket exclusion like the one we are removing may prevent some members from receiving the drugs they need. Prescriptions are subject to approval.	
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Virtual Visits (Telehealth Services)	All Handbooks except Personal Option	Renaming Virtual Visits to Telehealth Services to clearly reflect how PHP and health industry refers to benefit	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** ➢ Some Services are covered only under your In-Network benefits: • Virtual Visits, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Virtual Visits (see section 4.3.2). ***** --- **4.3.2 Virtual Visits** The Plan provides coverage for Virtual Visits with In-Network Providers using secure internet technology: • Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release. • Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat,	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** • Some Services are covered only under your In-Network benefits: • Telehealth Services, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Telehealth Services (see section 4.3.2). ***** --- **4.3.2 Telehealth Services** Telehealth services are services delivered through a variety of web-based or telecommunication technologies. The plan covers Telehealth services, when medically necessary and generally accepted healthcare practices and standards determine they can be safely and effectively provided using web-based or telecommunication technologies. **4.3.2.1 On-Demand Virtual Visits** Visits using a dedicated branded, web-based platform (such as Providence ExpressCare Virtual) through a tablet, smartphone, or computer for same-day appointments with a healthcare provider. Benefits will apply, as shown in your Benefit Summary.	No	No	This change has no impact on member benefits. We are removing the term "Virtual Visits" since we do not use that term to describe these services anymore, and to reduce member confusion. The term "Virtual Visits" is replaced with the term "Telehealth Services," which is an industry standard. We are also revising language to more clearly describe how Telehealth benefits are administered.	
	--- All Handbooks	--- Language changes to align with PHP's administration of benefit						

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			allergy, earache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.	**4.3.2.2 Office Visits Virtually** Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom. Benefits will apply, as shown in your Benefit Summary. **4.3.2.3 Telemedicine Services** Telemedicine Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; • Is delivered through a two-way ~~video~~ communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedicine Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member or another health professional on a Member's behalf, who is at an originating site. ***** **4.3.4 Telephone visits** Plan covers scheduled audio-only Office Visits for ~~established~~ patients with an In-network Provider ***** **15. DEFINITIONS**			Modifying a previously presented language change. We have replaced "Telemedical" with "Telemedicine" to conform with the industry standard language. Removing the word "video" since these services are also provided via audio-only communication.	

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			*****	The following are definitions of important capitalized terms used in this Member Handbook. ***** **Providence ExpressCare Virtual Visits** Providence ExpressCare Virtual Visits can be utilized for common conditions; such as sore throat, cough, or fever, etc. using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments. Virtual Visits are with In-Network Providers who are contracted with Providence Health Plan to provide Providence ExpressCare Virtual. Benefits will apply, as shown in your Benefit Summary. See section 4.3.2 for more details. *****				
		Telemedical Services moved above to section 4.3.2.3 and replaced with Telephone visits in section 4.3.4	**4.3.4 Telemedical Services** Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; and • Is delivered through a two-way video communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or				Making a corrective edit to a previously presented change that removes the word "established" as it is not a requirement; new patients may also receive these services. This is not a change in benefits and is only a language change.	

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		Updating definitions based on changes above; Adding Providence ExpressCare Virtual Visits definition; Removing Virtual Visits definition as that term is no longer used in section 4.3.2	transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site. ***** **15. DEFINITIONS** The following are definitions of important capitalized terms used in this Member Handbook. ***** **Virtual Visit** Virtual Visit means a visit with an In-Network Provider using secure internet technology: • Phone and Video Visit: Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2). • Web-direct Visit: Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, earache, sinus pain or UTI (see also section 4.3.2).					
Women's Health Care Services	Personal Option, HSA and Option	Adding language to call out that women can self-refer to a women's	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a	No	Yes	We are adding language to clarify that a woman can access a women's health care provider without a referral for any type of plan, as required by both federal ACA and state	

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	Advantage Handbooks --- All Handbooks	health care provider	physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES** Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.	physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES** Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider without a referral. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.			reproductive equity laws. This protects a woman's right to directly access certain health care practitioners for women's health care services.	
Updating language on HSA Qualified status	HSA Qualified Handbooks	Adding clarification that HSA qualification means that it may be paired with an employer sponsored HSA and HSA status is not automatic with enrollment in the Health Plan Adding detail that plan is disqualified as an HSA Qualified plan if it is provided in	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan for use in connection with a Health Savings Account (HSA). ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. ***** **15. DEFINITIONS**	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan (HDHP) for use in connection with a Health Savings Account (HSA). Your eligibility for this HDHP means that it may be paired with an employer-sponsored HSA. However, HSA-Qualified plan status is not automatic with enrollment in this HDHP alone. Additional steps are required to pair this Plan with an HSA. ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. This Plan is also disqualified as an HSA-Qualified plan if it is provided alongside a Health Reimbursement Account (HRA). ***** **15. DEFINITIONS**	No	No	PHP is adding information to HSA books to explicitly state that HSA plans that are coupled with a Health Reimbursement Account (HRA) disqualifies the plan as HSA Qualified.	

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		conjunction with an HRA Adding reference to section 2.1 from HSA and HDHP definitions for more information	***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with an HSA.	***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. See section 2.1 for more information on HSAs. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with an HSA. See section 2.1 for more information on HDHPs.				
Removing list of services requiring prior authorization from handbooks	All Handbooks	Removing list of services requiring prior authorization and directing members to the list on our website	**3.5 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. • Anesthesia Care with Diagnostic Endoscopy; • All Travel Expense Reimbursement, as provided in section 3.6. • All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health, and Chemical Dependency, as provided in sections 4.10 and 4.10.3. • All Applied Behavior Analysis Services, as provided in section 4.10.2. • All Human Organ/Tissue Transplant Services, as provided in section 4.13. • All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.	**3.5 PRIOR AUTHORIZATION** ***** **Services requiring Prior Authorization:** • A comprehensive list of services and supplies that must be Prior Authorized is available by visiting our website at ProvidenceHealthPlan.com/PriorAuthorization. You may also contact Customer Service to inquire whether a service or supply requires Prior Authorization. You or your Provider should submit Prior Authorization requests by following the instructions on our website. We will not require Prior Authorization for services and supplies that by law do not require Prior Authorization, including Emergency Room services. ***** **4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive	No	No	For 2022, PHP is removing the Prior Authorization (PA) list from all handbooks to eliminate the need to maintain and update this list in multiple sources and to reduce the risk of misalignment between these sources as the PA list changes over time. Going forward, our public-facing ProvLink site, which is fully accessible by all PHP members and providers, will become the single source of truth for our PA lists for our ASO groups.	

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			• All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7. • All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1. • All Sleep Study Services, as provided in section 4.4.2. • Certain Home Health Care Services, as provided in section 4. 11.1. • Certain Hospice Care Services, as provided in section 4.11.2. • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9. • Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. • All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6. • All Genetic Testing Services, as provided in section 4.12.1. • Certain Bariatric Surgery Services, as provided in section 4.12.17. • Certain medications, including certain immunizations, received in your Provider's office, as provided in sections 4.3.5 and 4.1.2. • Certain prescription drugs specified in our Formulary, as provided in section 4.14.1. • Certain infused or injected medications that are clinically indicated for administration by a health care professional. • Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria				

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		Removing references to specific services being specified in Prior Authorization section as we are removing the list from the Handbooks	**4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are	is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for more information on services requiring Prior Authorization. ***** **15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. More information about Prior Authorizations are shown in section 3.5.				

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		Clarifying that "select" surgical procedures are covered, whereas before language could be interpreted as ALL surgical procedures	corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization. ***** **15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.5.					

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

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Our Members wording	All Handbooks	Removing use of words "our Members"	**3.8 MEDICALLY NECESSARY SERVICES** We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.	**3.8 MEDICALLY NECESSARY SERVICES** We believe you are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.	No	No	Removing use of "our members" is a PHP marketing initiative. Changing here to stay consistent across all materials.	
Adding eviCore PA language	Groups who use eviCore for Outpatient Rehabilitation PA managem-ent	Adding language that describes PHP uses eviCore for PA of physical therapy and occupational therapy services	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity.	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity. Providers make notifications for outpatient rehabilitation services through an authorizing agent. A notification is the initial request submitted to the authorizing agent to inform Providence Health Plan that you are starting physical therapy and/or occupational therapy services. The authorizing agent determines if the requests are approved or require medical necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab.	No	No	For ASO groups that currently use eviCore for Prior Authorization of physical therapy and occupational therapy services ONLY. If you do not use eviCore for this purpose, this change does NOT apply to you. We are adding language to state that we use an authorizing agent (eviCore) for PT and OT services, and also adding a link that directs to our website for more information about eviCore. Making edit to previously presented change to clarify this process and specify eviCore as a delegate rather than a TPA.	
Genetic Testing and Counseling Services	All Handbooks	Addition of language to clarify that select genetic testing requires Prior Authorization	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are	No	No	Clarifying requirements for certain genetic testing services and directing to the handbook section for Prior Authorization	

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			in medical interventions and solutions that are corrective or therapeutic in nature.	corrective or therapeutic in nature. Select genetic testing requires Prior Authorization, for more information see section 3.5.				
Brand name drug coverage	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating language to explain how brand name drugs may be excluded if a generic exists	**4.14.1 Using Your Prescription Drug Benefit** • If you or your physician chooses a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.	**4.14.1 Using Your Prescription Drug Benefit** • • If a generic equivalent exists or becomes available, or if the cost of a brand-name drug changes, the tier placement of the brand-name drug may change, may require Prior Authorization, or the brand-name drug may no longer be covered. Additionally, if you choose a brand-name drug when a generic is available, you will be required to pay for the difference in cost between the brand-name drug and the generic drug, and the difference in cost will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.	No	No	To provide more transparency in how drugs are currently covered and how they will be setup to process in 2022.	
Growth hormone language	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are moving the growth hormone language from prescription drug limitations to prescription drug exclusions	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** 5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults. ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 2. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 3. Medications, drugs or hormones prescribed to stimulate growth, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults;	No	No	The exclusions section is a more suitable section for this language	
Replacement medications	All Handbooks that use PHP for Pharmacy Benefits	Modifying language to explicitly state damaged medications are excluded	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost, stolen, or damaged medication;	No	No	To provide transparency on the exclusion of replacing damaged medications.	

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	Managem-ent							
Blister or bubble repackaging	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Adding language regarding blister or bubble repackaging to prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 13. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication; 13. Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging for the place of service submitted;	No	No	To provide transparency on the exclusion of repackaged medications unless it is the pharmacy's standard packaging.	
Out-of-network pharmacy use	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are adding out-of-network pharmacy use to our prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and 22. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.	No	No	To provide transparency on direct member reimbursements and the use of out-of-network pharmacies unless in urgent/emergent situations	
Urgent PA response time	All handbooks	Aligning urgent PA response time language with PHP operational standards	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received.	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 72 hours after the Prior Authorization request is received.	No	No	This change **only applies** to ASO groups with traditional ERISA-subject self-funded plans. It does **not** apply to any ASO groups with non-ERISA ASO governmental plans that are either required to or choose to follow state law. Minor language correction to accurately reflect our current and historical operational practice	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) ASO grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.	If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.			for urgent prior authorization requests. Operationally, PHP has always responded to urgent PA requests within the 72-hour time frame specified by ERISA for traditional ASO self-funded plans. No practical impact to members, no PA claim administration change; this is a corrective handbook language edit only.	
Coordination of Benefits with Medicare	All Handbooks	Adding language for Medicare disabled/ESRD patients	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.	No	No	We are adding a paragraph that explains that the Coordination with Medicare rules may not apply to disabled people under 65 and ESRD patients, and direct members to the Medicare.gov website for more information.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) ASO grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			• Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.	• Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan. **Medicare disabled and end-stage renal disease (ESRD) patients**: The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare; please see the Medicare website, Medicare.gov, for more information.				
Section 7.2.4 External Review	All Handbooks	Bolding the sentence outlining the timeline for release of medical records in the event of an External Review, requires emphasis Per the recent updates to 743B.254 in HB 2046	**7.2.4 External Review** **** If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.	**7.2.4 External Review** **** **If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review.** The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.**	No	Yes	This change **only applies** to non-ERISA ASO governmental plans that are either required to or choose to follow state law. It does **not** apply to any ASO groups with traditional ERISA-subject self-funded plans.	Section 7.2.4 External Review

EXHIBIT C

Providence Health Plans – 2022 Benefit Summaries

Your Benefit Summary

Personal Option Plan

Clackamas County POA

Administered by 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 Summary Plan Description, 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 Summary Plan Description for details.

Benefit Highlights	You pay the following for covered services Copay or Coinsurance (from participating providers only)
Physician / Provider Services	
• Office visits	$15 / visit
• Phone and video visits	$5 / visit
• Providence ExpressCare Retail Health Clinics	$15 / visit
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations; shots	Covered in full
• Maternity services: prenatal	Covered in full
• Maternity services: delivery and postnatal	$150 / delivery
• Allergy shots; serums; injectable medications	$15 / visit
• Inpatient hospital visits	Covered in full
• Surgery; anesthesia	Covered in full
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full
• Mammograms	Covered in full
Hospital Services	
• Inpatient care	Covered in full
• Observation care	Covered in full
• Maternity care	Covered in full
• Routine newborn nursery care	Covered in full
• Rehabilitative care (30 days per calendar year)	Covered in full
• Skilled nursing facility (60 days per calendar year)	Covered in full
Outpatient Diagnostic Services	
• X-ray; lab services	Covered in full
• Imaging services (such as PET, CT, MRI)	Covered in full
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
• Hearing Aids (one per ear every three calendar years)	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

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
• Chiropractic manipulation (Limited to 30 visits per calendar year)	$10 / visit*
• Acupuncture (Limited to 30 visits per calendar year)	$10 / visit*
• Massage therapy (Limited to 30 visits per calendar year)	$10 / visit*
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Home health care	Covered in full
• Hospice care	Covered in full
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)	
-Generic drugs	Covered in full
-Formulary brand-name drugs	Covered in full
-Non-formulary brand-name drugs	Covered in full
Mental Health / Chemical Dependency (To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient, residential services	Covered in full
• Day treatment, intensive outpatient and partial hospitalization services	Covered in full
• Applied behavior analysis	$15 / visit
• Outpatient provider office visits	$15 / visit

* Copayment does not apply to out-of-pocket maximums.

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 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.

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 Summary Plan Description 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: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary

Out-of-Area Dependent
Clackamas County POA

Administered by PROVIDENCE Health Plan

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

Important information about your plan

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

Benefit Highlights	You pay the following for covered services:
	Coinsurance
Physician / Provider Services	
• Office visits	20%
• Phone and video visits	5%
• Providence ExpressCare Retail Health Clinics	20%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations; shots	Covered in full
• Maternity services: prenatal	Covered in full
• Maternity services: delivery and postnatal	20%
• Allergy shots; serums; injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full
• Mammograms	Covered in full
Hospital Services	
• Inpatient care	20%
• Observation care	20%
• Maternity care	20%
• Routine newborn nursery care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Outpatient Diagnostic Services	
• X-ray; lab services	20%
• Imaging services (such as PET, CT, MRI)	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
• Hearing Aids (one per ear every three calendar years)	20%
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Emergency medical transportation	20%

Benefit Highlights (continued)

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

* Copayment does not apply to out-of-pocket maximums.

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 Summary Plan Description for details.

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

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

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

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

Contact us

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All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

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www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary

Open Option

Clackamas County POA

Administered by 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 Summary Plan Description, 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 penalities 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 Summary Plan Description for details.

Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Plan Copay or Coinsurance (after deductible, when you use a participating provider)	
Physician / Provider Services		
• Office visits	$10 / visit✓	20%✓
• Phone and video visits	$5 / visit✓	20%✓
• Providence ExpressCare Retail Health Clinics	$10 / visit✓	Not applicable
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	20%✓
• Vision and hearing screenings for children under 18	Covered in full✓	20%✓
• Routine immunizations; shots	Covered in full✓	20%✓
• Maternity services: prenatal	Covered in full✓	20%
• Maternity services: delivery and postnatal	$50 / delivery✓	20%
• Allergy shots; serums; injectable medications	Covered in full	20%
• Inpatient hospital visits	Covered in full	20%
• Surgery; anesthesia	Covered in full	20%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	20%✓
• Mammograms	Covered in full✓	20%
Hospital Services		
• Inpatient care	Covered in full	20%
• Observation care	Covered in full	20%
• Maternity care	Covered in full	20%
• Routine newborn nursery care	Covered in full✓	20%
• Rehabilitative care (30 days per calendar year)	Covered in full	20%
• Skilled nursing facility (60 days per calendar year)	Covered in full	20%
Outpatient Diagnostic Services		
• X-ray; lab services	Covered in full✓	20%
• Imaging services (such as PET, CT, MRI)	Covered in full✓	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year; deductible waived)	20%*	20%
• Hearing Aids (one per ear every three calendar years)	20%	20%

*Your deductible does not apply to purchase of diabetes supplies

**No deductible needs to be met prior to receiving this benefit. Copayment does not apply to out-of-pocket maximums.

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

*Your deductible does not apply to purchase of diabetes supplies
**No deductible needs to be met prior to receiving this benefit. Copayment does not apply to out-of-pocket maximums.

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.

Contact us

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www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary

Prescription Drug Plan
Clackamas County POA

Administered by 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 our network of 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/planpharmacies or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copays, coinsurance and any difference in costs for prescription drugs do not apply to your calendar year medical plan out-of-pocket maximums or deductibles.

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

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you request a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded drugs are medications 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 be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- 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.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website. If a formulary exception is approved, your generic or brand-name cost share will apply.
- 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.

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 and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Brand-name drugs.

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 usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as 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. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

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 Summary Plan Description.

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

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

Contact us
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: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

EXHIBIT D

Kaiser Permanente Medical and Dental 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: 1183 POA Custom C22B-007 KOM 2022

Region: Northwest
Contract Period: 01/01/2022 - 12/31/2022
Report Period: Mar 2020 through Feb 2021

	Mar20-Feb21
Average Members:	2,359

Rating Month: March 2021
Rating Members: 407

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$11,325,566	$400.055
A2	- Pooling Credit	Pooling Point:$325,000			0	0.000
A3	+ Pooling Charge				176,371	6.230
A4	Claims Net of Pooling				$11,501,938	$406.285
A5	X Incurred Claims Adjustment			1.00388		
A6	X Demographic Change			1.00394		
A7	X Historical Benefit Change			1.030870		
A8	Adjusted Claims					$422.109
A9	X Trend Factor	Annual Trend: 13.34%		1.25814		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$531.072
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$216,146	$531.072
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$216,146	$531.072
D4	+ Retention		15,096	37.090
D5	+ Other Benefits		5,869	14.420
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal PCORI Fee		94	0.230
D9	+ Premium Tax		4,841	11.894
D10	+ Commission		0	0.000
D11	**Uncapped PMPM Premium Requirement**		**$242,045**	**$594.706**
E	**Capping**	**Increase**		
E1	In-Force Rate		$229,730	$564.447
E2	Premium Requirement without Changes and Underwriter Adjustment	5.19%	241,655	593.747
E3	Capping Rate	6.15%	243,865	599.176
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**6.32%**	**244,255**	**600.135**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**6.32%**	**244,255**	**600.135**
E7	Capping Adjustment		2,210	5.429

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: 1183 POA Custom $1400 Ded 058 KONX 202

Region: Northwest
Contract Period: 01/01/2022 - 12/31/2022
Report Period: Mar 2020 through Feb 2021

	Mar20-Feb21
Average Members:	2,359
Rating Month:	March 2021
Rating Members:	24

Medical Calculation

			Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$11,325,566	$400.055
A2	- Pooling Credit	Pooling Point:$325,000			0	0.000
A3	+ Pooling Charge				176,371	6.230
A4	Claims Net of Pooling				$11,501,938	$406.285
A5	X Incurred Claims Adjustment			1.00388		
A6	X Demographic Change			1.00394		
A7	X Historical Benefit Change			0.685680		
A8	Adjusted Claims					$280.762
A9	X Trend Factor	Annual Trend: 13.34%		1.25814		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$353.238
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$8,478	$353.238
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$8,478	$353.238
D4	+ Retention		890	37.090
D5	+ Other Benefits		342	14.270
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal PCORI Fee		6	0.230
D9	+ Premium Tax		198	8.262
D10	+ Commission		0	0.000
D11	**Uncapped PMPM Premium Requirement**		**$9,914**	**$413.090**
E	**Capping**	**Increase**		
E1	In-Force Rate		$9,548	$397.837
E2	Premium Requirement without Changes and Underwriter Adjustment	3.63%	9,895	412.284
E3	Capping Rate	6.15%	10,136	422.315
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**6.36%**	**10,155**	**423.121**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**6.36%**	**10,155**	**423.121**
E7	Capping Adjustment		241	10.031

EXHIBIT E

Kaiser Permanente – 2022 Contract Changes

Summary of 2021 to 2022 Oregon Plan Changes

The following changes were made to
large group standard plan designs for 2022.

What's new at Kaiser Permanente

Below are some highlights of changes over the last year.

Medical plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Alternative care	Alternative care benefits (acupuncture, chiropractic, naturopathic, and massage therapy) updated for 2022 plan year. See the alternative care benefit changes table below. Alternative care exclusions list updated for consistency and to remove exclusions that are not specific to alternative care providers and services and/or are addressed in general exclusions or in other benefit sections. Alternative care covered services descriptions in the benefit section of the *Evidence of Coverage (EOC)* and the riders are standardized.	Simplify benefits, offer easier access for members, and meet market needs with flexible offerings that allow group customers to select the cost and coverage that is right for their needs. The benefit changes also meet the new essential health benefits (EHBs) requirements in Oregon. Benefit description enhancement. Benefit description enhancement.
Bariatric surgery services	Updated the benefit description in the *EOC* to clarify that the benefit covers the surgery procedures **and** related pre-surgery and post-surgery and includes two key points about the criteria: services for clinically severe obesity in adults are covered; and the member must receive the surgical services at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). Members may contact Member Services to request our criteria and get a list of the approved surgical procedures covered when criteria are met.	Benefit description enhancement.
Gender-neutral language	Existing contract language that contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Heathy Resources	Added a new “Healthy Resources” section to OR *EOCs* to explain value-added programs and resources available to members.	In compliance with disclosure requirements under ORS 746.035 and ORS 746.045.
Improved provider definitions	Several provider definitions have been modified.	Standardization between OR and WA, and consistency across product types.
Insulin for treatment of diabetes	Limits the cost sharing for insulin for the treatment of diabetes to $75 for a 30-day supply and $225 for a 90-day supply. Coverage may not be subject to a deductible.	Benefit enhancement to comply with OR HB 2623. Aligns insulin treatment cost shares across both OR and WA.

Benefit	Summary of changes	Reason for change
Medical coverage of dental services for potential transplant recipients	Additional coverage in medical plans for members who are potential transplant recipients. Routine dental services necessary to ensure the oral cavity is clear of infection so the member can be placed on the transplant waitlist will be covered.	Expanded coverage to remove oral care barriers for transplant patients.
Outpatient prescription drugs — preventive drug tier	Modified prescription drug riders that include a preventive drug tier to include a more comprehensive description of what a preventive drug is and clarified that this drug tier does **not** include preventive drugs required under ACA.	Benefit clarification.
Provider networks to replace benefit tiers	Replaced references to benefit "tiers" with language that explains coverage in terms of provider networks, cost shares, and how to obtain services.	Simplified for improved readability and understanding.
Subrogation	Modified the *EOC* section that addresses other party liability to clarify the member's role in helping us recover amounts from a claim settlement, judgment, or award from a third party.	Clarification of member's role.
Telehealth	Enhanced descriptions of telehealth services in the OR *EOCs.* An additional section in the OR Benefit Summaries will show the cost share for various types of telehealth services.	Enhanced benefit description.
Transplant services	Revised benefit description in the *EOC* to make it clearer that both inpatient and outpatient services related to covered transplants are covered at the cost share applicable to the service/place of service.	Benefit description enhancement.
Transplant services	Removed transplant description in OR *EOC* benefit summary section. In addition, the revised *EOC* transplant services language provides better clarity on covered transplant services.	Benefit clarification.

Alternative care benefit changes

Service type	2021		2022	
	Physician-referred	Self-referred	Physician-referred	Self-referred
Acupuncture care	Specialty office visit cost share, 12-visit limit.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).
Chiropractic care	Specialty office visit cost share.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).
Massage therapy	Not applicable.	Rider offering.	Not applicable.	Rider offering.
Naturopathic care	Specialty office visit cost share.	Rider offering.	Not covered.	Included in base plans at the primary office visit cost share with no visit limit.

Dental benefit plan changes

Benefit	Summary of changes	Reason for change
Dental plans that include coverage for dental implants: modifying implant cleaning and maintenance benefits	We cover routine cleaning of the implant surfaces up to 2 visits per year; and implant maintenance, where the prosthesis is removed and reinserted, once every 2 years. We will cover dental implant maintenance regardless of whether a Kaiser Permanente provider placed the implant system.	Improve dental implant care.
Gender-neutral language	Existing contract language that contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Subrogation	Modified the *EOC* section that addresses other party liability to clarify the member's role in helping us recover amounts from a claim settlement, judgment, or award from a third party.	Clarification of member's role.

New ways we are providing quality, providing convenience, and serving our mission

Getting care from the comfort of home

Your employees can rest assured knowing they can continue to get the high-quality care they depend on for all their health care needs. For primary care, specialty care, and mental health services, they can connect with their care team with e-visits, video visits, or phone appointments. *

*When appropriate and available. These features apply to care you get at Kaiser Permanente facilities.

Self-care at your fingertips — at no additional cost to members

We offer 2 digital self-care apps, Calm and myStrength, at no additional cost to members to help support their mental health and emotional well-being. *

*Only available to Kaiser Permanente members with medical coverage. myStrength® is a wholly owned subsidiary of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc.

Finding funding opportunities to manage the uncertainty of the current economic environment

We recently launched the Resilience Compass, a website that helps diverse businesses and employers find the support resources they need to help them succeed, especially in these tough economic times.

Visit **resiliencecompass.org** to find resources on training, funding, discounts, and more.

Getting dental advice at home

Members can send photos and communicate with their dental team via email through kp.org and the Kaiser Permanente app.*

*When appropriate and available. To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.

Getting connected to an interpreter, made easier

Members can now call the interpretation services number on the back of their Kaiser Permanente ID card to go through a new flow that connects them directly with an interpreter.

Bringing healing home with virtual cardiac rehabilitation

Kaiser Permanente is home to Oregon's first virtual cardiac rehab program. In its first year, 87% of participants completed Kaiser Permanente's 8-week virtual rehab program using wearable technology, compared with a less than 50% national average completion rate for those attending in-person rehab programs. *

*Randal J. Thomas et al., "Home-Based Cardiac Rehabilitation: A Scientific Statement from the American Association of Cardiovascular and Pulmonary Rehabilitation, the American Heart Association, and the American College of Cardiology," *Circulation,* July 2, 2019, p. e69. pubmed.ncbi.nlm.nih.gov/31097258

Seeking tomorrow's cure, today

Our cancer team is at the forefront of clinical trials, testing immunotherapy and other treatments that give patients more options for leading-edge care. In fact, Kaiser Permanente is a part of one of the largest cancer clinical research groups in the country. *

*Kaiser Permanente Center for Health Research, research.kpchr.org/Research/Research-Areas/Cancer, accessed April 9, 2021.

Furthering our mission with community health

We help people experiencing health inequities address the clinical, genetic, social, economic, and environmental factors that affect their ability to thrive. In 2019 alone, we invested more than $3.4 billion in the community. *

*2019 Kaiser Permanente Community Health Snapshot, about.kaiserpermanente.org/content/dam/internet/kp/comms/community-health/kp-community-health-snapshot-2019.pdf.

Summary of 2021 to 2022 Oregon Plan Changes

The following changes were made to
large group standard plan designs for 2022.

What's new at Kaiser Permanente

Below are some highlights of changes over the last year.

A new total health care option — our Complete Suite™ portfolio, with NEW Dual Choice PPO™ and Virtual Complete™ plans

Complete Suite refers to our portfolio of health plans available to employer groups with 51–499 eligible employees.

Choose a traditional plan or pair with our new Dual Choice PPO plans. Get a single-carrier solution with network choices your employees want. This means streamlined benefit administration for you, and an expanded network for your employees.

Dual Choice PPO

Dual Choice PPO plans provide you with flexibility to **offer nationwide coverage to employees —** through access to Kaiser Permanente providers, First Choice Health providers, First Health Network providers, other direct-contract providers, or any licensed provider. These plans must be offered alongside a traditional, deductible, or HDHP plan.

Lower cost shares using an enhanced benefit — Some in-network providers, including Kaiser Permanente, have lower cost shares for primary care, urgent care, specialty care, and routine eye exam visits. This is referred to as an enhanced benefit.

Virtual Complete

New Virtual Complete plans are available for both deductible plans and Dual Choice PPO plans. Eight new plans offer members flexibility in how they choose to get care — **taking advantage of our many virtual care options at no additional cost,** while still having primary care access to in-person care whenever they need it.

Members can connect with their care team and specialists they've been referred to by video or phone for $0.* They can also have a **set number of in-person primary care visits with a copay before meeting their deductible.**

*When appropriate and available. These features are available when you get care from Kaiser Permanente.

Medical plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Alternative care	Alternative care benefits (acupuncture, chiropractic, naturopathic, and massage therapy) updated for 2022 plan year. See the alternative care benefit changes table below. Alternative care exclusions list updated for consistency and to remove exclusions that are not specific to alternative care providers and services and/or are addressed in general exclusions or in other benefit sections. Alternative care covered services descriptions in the benefit section of the Evidence of Coverage (EOC) and the riders are standardized.	To simplify benefits, offer easier access for members, and meet market needs with flexible offerings that allow group customers to select the cost and coverage that is right for their needs. The benefit changes also meet the new Essential Health Benefits (EHBs) requirements in Oregon. Benefit description enhancement Benefit description enhancement
Medical coverage of dental services for potential transplant recipients	Additional coverage in medical plans for members who are potential transplant recipients. Routine dental services necessary to ensure the oral cavity is clear of infection so the member can be placed on the transplant waitlist will be covered.	Expanded coverage to remove oral care barriers for transplant patients.
Insulin for treatment of diabetes	Limits the cost sharing for insulin for the treatment of diabetes to $75 for a 30-day supply and $225 for a 90-day supply. Coverage may not be subject to a deductible.	Benefit enhancement to comply with OR HB 2623. Aligns insulin treatment cost shares across both OR & WA.
Provider networks to replace benefit tiers	Replaced references to benefit “tiers” with language that explains coverage in terms of provider networks, cost shares, and how to obtain services.	Simplified for improved readability and understanding.
Improved provider definitions	Several provider definitions have been modified.	Standardization between OR and WA, and consistency across product types.
Gender neutral language	Existing contract language which contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Bariatric Surgery Services	Updated the benefit description in the EOC to clarify that the benefit covers the surgery procedures **and** related pre-surgery and post-surgery and includes two key points about the criteria: services for clinically severe obesity in adults are covered; and the member must receive the surgical services at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality	Benefit description enhancement.

	Improvement Program (MBSAQIP). Members may contact Member Services to request our criteria and get a list of the approved surgical procedures covered when criteria is met.	
Transplant Services	Revised benefit description in the EOC to make it clearer that both inpatient and outpatient services related to covered transplants are covered at the cost share applicable to the service / place of service.	Benefit description enhancement.
Outpatient prescription drugs – preventive drug tier	Modified prescription drug riders that include a preventive drug tier to include a more comprehensive description of what a preventive drug is and clarified that this drug tier does not include preventive drugs required under ACA.	Benefit clarification.
Heathy Resources	Added a new "Healthy Resources" section to OR EOCs to explain value-added programs and resources available to members.	In compliance with disclosure requirements under OR law, ORS 746.035 and ORS 746.045
Telehealth	Enhanced descriptions of telehealth services in the OR EOCs. An additional section in the OR Benefit Summaries will show the cost share for various types of telehealth services.	Enhanced benefit description.
Transplant Services	Removed transplant description in OR EOC benefit summary section. In addition, the revised EOC transplant services language provides better clarity on covered transplant services.	Benefit clarification.
Subrogation	Modified the EOC section that addresses other party liability to clarify the member's role in assisting us to recover amounts from a claim settlement, judgement, or award from a third party.	Clarification of member's role.

Alternative care benefit changes

Service type	2021		2022	
	Physician-referred	Self-referred	Physician-referred	Self-referred
Acupuncture care	Specialty office cost share,12-visit limit.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).
Chiropractic care	Specialty office cost share.	Rider offering.	Not covered.	Rider offering with specific cost share options and visit limit options, and no dollar benefit maximum. Now an essential health benefit (EHB).

Naturopathic care	Specialty office cost share.	Rider offering.	Now Under Primary Care.	Included in base plans at the primary office visit cost share with no visit limit.
Massage therapy	Not applicable.	Rider offering.	Not applicable.	Rider offering.

Deductible health plans

Summary of changes	Reason for change
Virtual Complete deductible plans can be offered alongside an aligned Dual Choice PPO offering.	Expand product offering.
In most cases, groups can keep their current plan except where noted.	Reduce marketed plans.

Plans affected	Changed from	Changed to
Virtual Complete deductible plans: DED PLAN VC 2500/40/20%/5500 DED PLAN VC 3000/40/30%/6000 DED PLAN VC 4000/50/30%/7000 DED PLAN VC 5000/50/40%/8000	Plans not offered.	Four new plans offered in Oregon.
DED PLAN AA 150/15/20%/1650 DED LGY 750/20/20%/2250 DED PLAN F 2000/25/20%/5500 DED PLAN J 4000/30/20%/7350 DED PLAN LGY 5000/30/20%/7350 DED PLAN K 5000/30/20%/7500 **All deductible value plans:** DED PLAN ValueNQ 30% DED PLAN ValueNQ 40% DED PLAN ValueNQ 50% And all related buy-ups	Plans offered.	Plans discontinued. Groups can keep their current plan. If there are any changes to benefits, the group should select a new plan. Please discuss your group's transition needs with your Kaiser Permanente account manager.

High deductible health plans (HSA-qualified)

Summary of changes		Reason for change
Maximum out-of-pocket adjustments to high deductible health plans.		Align with IRS maximums.
In most cases, groups can keep their current plan except where noted.		Reduce marketed plans.
Plans affected	**Changed from**	**Changed to**
All HDHP minimum value plans: HDHP PLAN LGY MV $3500 EE 50% HDHP PLAN MV $4500 EE 40% HDHP PLAN LGY MV $5500 EE 30% And all customized variations of these plans	Plans offered.	Plans discontinued. Groups currently on these plans will be asked to move to a new HDHP plan. Please discuss your group's transition needs with your Kaiser Permanente account manager.
HDHP PLAN $6900/0% HDHP PLAN AA 1400/10%/2800 HDHP PLAN AA 1400/20%/2800 HDHP PLAN A 1500/30%/2500 HDHP PLAN A 1500/10%/3500 HDHP PLAN A 1500/20%/3500 HDHP PLAN A 1500/30%/3500 HDHP PLAN B 2000/10%/4000 HDHP PLAN B 2000/50%/4000 HDHP PLAN C 2500/10%/5000 HDHP PLAN C 2500/50%/5000 HDHP PLAN D 2800/10%/4000 HDHP PLAN D 2800/20%/4000 HDHP PLAN D 2800/30%/4000 HDHP PLAN D 2800/40%/4000 HDHP PLAN D 2800/40%/5600 HDHP PLAN D 2800/50%/5600 HDHP PLAN E 3000/40%/6000 HDHP PLAN E 3000/50%/6000 HDHP PLAN F 3500/40%/6900 HDHP PLAN F 3500/50%/6900 HDHP PLAN G 4000/50%/6900 HDHP PLAN H 5000/50%/6900	Plan offered.	Plans discontinued. Groups can keep their current plan. Any change to benefits will require selecting a new plan from the Complete Suite offering.

HDHP PLAN A 1500/20%/3500	Individual maximum out-of-pocket: $2,500 Family maximum out-of-pocket: $5,000 Plan name: HDHP PLAN A 1500/20%/2500	Individual maximum out-of-pocket: $3,500 Family maximum out-of-pocket: $7,000 Plan name: HDHP PLAN A 1500/20%/3500
HDHP PLAN F 3500/20%/7000 HDHP PLAN F 3500/30%/7000 HDHP PLAN G 4000/20%/7000 HDHP PLAN G 4000/30%/7000 HDHP PLAN G 4000/40%/7000 HDHP PLAN H 5000/20%/7000 HDHP PLAN H 5000/30%/7000 HDHP PLAN H 5000/40%/7000 HDHP PLAN H 5000/50%/7000	Individual maximum out-of-pocket: $6,900 Family maximum out-of-pocket: $13,800 Plan name: Maximum out-of-pocket in plan name was $6,900.	Individual maximum out-of-pocket: $7,000 Family maximum out-of-pocket: $14,000 Plan name: Maximum out-of-pocket in plan name changed to $7,000. Groups can keep their current plan.

Dual Choice PPO™ plans

Summary of changes	Reason for change
Maximum out-of-pocket adjustments to high deductible health plans.	Comply with IRS change.
Dual Choice Virtual Complete plans added for pairing with standard deductible plans as part of the new Virtual Complete offering.	Expand product offering.
We're removing prior authorization requirements for outpatient rehabilitation therapies. Members will have direct access to physical therapy, occupational therapy, and speech therapy providers for both in and out-of-network providers. The therapist's office may still request a referral.	Improve member access to therapies.

Plans affected	Changed from	Changed to
Dual Choice PPO Virtual Complete deductible plans: PPO PLAN VC 2500/40/20%/6500 PPO PLAN VC 3000/40/30%/7000 PPO PLAN VC 4000/50/30%/8150 PPO PLAN VC 5000/50/40%/8150	Plans not offered.	Four new plans offered in Oregon.

PPO HDHP PLAN A 1500/20%/3500	In-network individual maximum out-of-pocket: $2,500 In-network family maximum out-of-pocket: $5,000 Out-of-network individual maximum out-of-pocket: $10,500 Out-of-network family maximum out-of-pocket: $21,000 Plan name: PPO HDHP PLAN A 1500/20%/2500	In-network individual maximum out-of-pocket: $3,500 In-network family maximum out-of-pocket: $7,000 Out-of-network individual maximum out-of-pocket: $11,500 Out-of-network family maximum out-of-pocket: $23,000 Plan name: PPO HDHP PLAN A 1500/20%/3500
PPO HDHP PLAN F 3500/20%/7000 PPO HDHP PLAN F 3500/30%/7000 PPO HDHP PLAN G 4000/20%/7000 PPO HDHP PLAN G 4000/30%/7000 PPO HDHP PLAN G 4000/40%/7000 PPO HDHP PLAN H 5000/20%/7000 PPO HDHP PLAN H 5000/30%/7000 PPO HDHP PLAN H 5000/40%/7000	Individual maximum out-of-pocket: $6,900 Family maximum out-of-pocket: $13,800 Plan name: Maximum out-of-pocket in plan name was $6,900.	Individual maximum out-of-pocket: $7,000 Family maximum out-of-pocket: $14,000 Plan name: Maximum out-of-pocket in plan name changed to $7,000. Groups can keep their current plan.

Added Choice® point-of-service plans

Summary of changes		Reason for change
New Dual Choice PPO offering is intended to replace Added Choice point-of-service plans.		Transition to Dual Choice.
We're removing prior authorization requirements for outpatient rehab therapies for services received from PPO and non-participating providers. Members will have direct access to physical therapy, occupational therapy, and speech therapy providers. The therapist's office may still request a referral.		Improve member access to therapies.
Plans affected	**Changed from**	**Changed to**

All Added Choice point-of-service plans	Plans offered to groups.	Product is being phased out. Groups currently on these plans will be asked to move to a new Dual Choice PPO plan within one renewal cycle. Please discuss your group's transition needs with your Kaiser Permanente account manager.
All Added Choice point-of-service deductible plans — renewals only	PPO network TMD benefit not subject to deductible.	PPO network TMD benefit subject to deductible.

Out-of-area PPO Plus® plans

Summary of changes		Reason for change
Out-of-area PPO Plus plans will continue to be offered alongside Dual Choice PPO plans for out-of-area members.		Continue out-of-area access.
Maximum out-of-pocket adjustments to high deductible health plans to better align with IRS changes and across aligned products.		Align with IRS changes.
We're removing prior authorization requirements for outpatient rehab therapies for services received from PPO and non-participating providers. Members will have direct access to physical therapy, occupational therapy, and speech therapy providers. The therapist's office may still request a referral.		Improve member access to therapies.
Plans affected	**Changed from**	**Changed to**
PPO PLUS HDHP AA PLAN WFI 1500/20%/3500	PPO network individual maximum out-of-pocket: $2,500 PPO network family maximum out-of-pocket: $5,000 Non-participating provider individual maximum out-of-pocket: $5,000 Non-participating provider family maximum out-of-pocket: $10,000 Plan name: PPO PLUS HDHP AA PLAN WFI 1500/20%/2500	PPO network individual maximum out-of-pocket: $3,500 PPO network family maximum out-of-pocket: $7,000 Non-participating provider individual maximum out-of-pocket: $6,000 Non-participating provider family maximum out-of-pocket: $12,000 Plan name: PPO PLUS HDHP AA PLAN WFI 1500/20%/3500

PPO PLUS HDHP AA PLAN WAS 2800/20%/4000	Non-participating provider individual maximum out-of-pocket: $5,000 Non-participating provider family maximum out-of-pocket: $10,000	Non-participating provider individual maximum out-of-pocket: $7,000 Non-participating provider family maximum out-of-pocket: $14,000

Dental benefit plan changes

Benefit	Summary of changes	Reason for change
Dental plans that include coverage for dental implants: modifying implant cleaning and maintenance benefits.	We cover routine cleaning of the implant surfaces up to 2 visits per year; and implant maintenance, where the prosthesis is removed and reinserted, once every 2 years. We will cover dental implant maintenance regardless of whether a Kaiser Permanente provider placed the implant system.	Improve dental implant care.
Gender neutral language	Existing contract language which contained he/him/his and she/her/hers has been replaced with they, them, the person.	Further support our inclusive best practices.
Subrogation	The EOC section that addresses other party liability has been modified to clarify the member's role in assisting us to recover amounts from a claim settlement, judgement, or award from a third party. Additional edits to WA EOCs expressly providing that the member be made whole and to allow for accidents or injuries occurring in non-Made-Whole states.	Clarification of member's role. Benefit clarification

New ways we are providing quality, providing convenience, and serving our mission

Getting care from the comfort of home

Your employees can rest assured knowing they can continue to get the high-quality care they depend on for all their health care needs. For primary care, specialty care, and mental health services, they can connect with their care team with e-visits, video visits, or phone appointments.*

*When appropriate and available. These features apply to care you get at Kaiser Permanente facilities.

Self-care at your fingertips — at no additional cost to members

We offer 2 digital self-care apps, Calm and myStrength, at no additional cost to members to help support their mental health and emotional well-being.*

*Only available to Kaiser Permanente members with medical coverage. myStrength® is a wholly owned subsidiary of Livongo Health, Inc.

Finding funding opportunities to manage the uncertainty of the current economic environment

We recently launched the Resilience Compass, a website that helps diverse businesses and employers find the support resources they need to help them succeed, especially in these tough economic times.

Visit **resiliencecompass.org** to find resources on training, funding, discounts, and more.

Getting dental advice at home

Members can send photos and communicate with their dental team via email through kp.org and the Kaiser Permanente app.*

*When appropriate and available. To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.

Getting connected to an interpreter, made easier

Members can now call the interpretation services number on the back of their Kaiser Permanente ID card to go through a new flow that connects them directly with an interpreter.

Bringing healing home with virtual cardiac rehabilitation

Kaiser Permanente is home to Oregon's first virtual cardiac rehab program. In its first year, 87% of participants completed Kaiser Permanente's 8-week virtual rehab program using wearable technology, compared with a less than 50% national average completion rate for those attending in-person rehab programs.*

*Randal J. Thomas et al., "Home-Based Cardiac Rehabilitation: A Scientific Statement From the American Association of Cardiovascular and Pulmonary Rehabilitation, the American Heart Association, and the American College of Cardiology," *Circulation,* July 2, 2019, p. e69. pubmed.ncbi.nlm.nih.gov/31097258

Seeking tomorrow's cure, today

Our cancer team is at the forefront of clinical trials, testing immunotherapy and other treatments that give patients more options for leading-edge care. In fact, Kaiser Permanente is a part of one of the largest cancer clinical research groups in the country.*

*Kaiser Permanente Center for Health Research, research.kpchr.org/Research/Research-Areas/Cancer, accessed April 9, 2021.

Furthering our mission with community health

We help people experiencing health inequities address the clinical, genetic, social, economic, and environmental factors that affect their ability to thrive. In 2019 alone, we invested more than $3.4 billion in the community.*

*2019 Kaiser Permanente Community Health Snapshot, about.kaiserpermanente.org/content/dam/internet/kp/comms/community-health/kp-community-health-snapshot-2019.pdf.

EXHIBIT F

Kaiser Permanente – 2022 Benefit Summaries

Summary of Dental Benefits

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

Membership Services: 1-800-813-2000

Oregon R086 **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183**

Benefit Maximum per Calendar Year	None
	You pay
Dental Office Visit Charge – Per visit	$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 (Not subject to or counted toward the Deductible)	
Oral exam	$0
X-rays	$0
Teeth cleaning	$0
Fluoride	$0
Minor Restoration Services	
Routine fillings	$0
Plastic and steel crowns	$0
Simple extractions	$0
Oral Surgery Services	
Surgical tooth extractions	$0
Periodontics	
Treatment of gum disease	$0
Scaling and root planing	$0
Endodontics	
Root canal therapy	$0
Major Restoration Services	
Gold or porcelain crowns	$45
Bridges	$45
Removable Prosthetic Services	
Full upper and lower dentures	$65
Partial dentures	$95
Relines	$25
Rebases	$25
Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)	
Adults and children age 13 years and older	$25
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.

Implants	50% Coinsurance up to the $2,000 Dental Implant Benefit Maximum.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

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

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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Summary of Medical Benefits

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

Member Services: 1-800-813-2000

Oregon **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183-030**

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible	
Self-only Deductible per Year (for a Family of one Member)	None
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	None
Family Deductible per Year (for an entire Family)	None
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$600
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$600
Family Out-of-Pocket Maximum per Year (for an entire Family)	$1,200
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0
Primary Care	$10
Specialty Care	$10
Urgent Care	$10
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$0 per department visit
X-ray, imaging, and special diagnostic procedures	$0 per department visit
CT, MRI, PET scans	$0 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$10 generic / $20 brand
Mail Order Prescription drugs (up to a 90 day supply)	$20 generic / $40 brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$0
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	$0 per department visit
X-ray, imaging, and special diagnostic procedures	$0 per department visit
Inpatient Hospital Services	$0

Hospital Services	**You pay**
Ambulance Services (per transport)	$75
Emergency services	$75 (Waived if admitted)
Inpatient Hospital Services	$0
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Durable medical equipment	$0
Physical, speech, and occupational therapies (20 visits per therapy per Year)	$10
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	$0
Mental Health and Chemical Dependency Services	**You pay**
Outpatient Services	$10 per visit
Inpatient hospital & residential Services	$0
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$10 per visit
Chiropractic Services (up to 20 visits per Year)	$10 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit
Naturopathic Medicine	$10 per visit
Vision Services	**You pay**
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	$10
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to $200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once in a two-Year period.

[1] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to **http://www.kp.org/plandocuments**

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

This is not a contract. This condensed summary of benefits 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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Kaiser Permanente Senior Advantage (HMO)
Summary of Medical Benefits Part D

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

Member Services: **1-877-221-8221** (TTY **711**)
8 a.m. to 8 p.m., 7 days a week

Oregon C22B **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183-007**

Deductible	
For one Member per Year	None
Out-of-Pocket Maximum[1]	
For one Member per Year	$600
Office visits	**You pay**
"Welcome to Medicare" preventive visit	$0
Primary Care	$10
Specialty Care[2†]	$10
Urgent Care	$10
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory[2†]	$0 per department visit
X-ray, imaging, and special diagnostic procedures[2†]	$0 per department visit
CT, MRI, PET scans[2†]	$0 per department visit
Medications (outpatient)	**You pay**

Prescription drugs†	$10 generic/$20 brand, for up to a 30-day supply, per prescription. When you get your drugs from our mail-order pharmacy, you may get up to a 31-90 day supply for two copayments. After you have paid $7,050 in true out-of-pocket costs for Part D covered drugs in a calendar year, you will pay the lesser of your copayment or $3 for generic drugs and $7 for brand drugs, per prescription.
Administered medications, including injections (all outpatient settings)†	$0
Nurse treatment room visits to receive injections†	$0
Hospital Services	**You pay**
Ambulance Services (per transport)	$50
Emergency department visit	$50
Inpatient Hospital Services[2†]	$0
Outpatient Services (other)	**You pay**
Outpatient surgery visit[2†]	$50
Chemotherapy/radiation therapy visit[2†]	$10
Durable medical equipment†	$0
Physical, speech, and occupational therapies[2†]	$10
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services up to 100 days per Medicare Benefit Period[2†]	$0
Mental Health and Substance Abuse Services†	**You pay**
Outpatient Services	$10
Inpatient Services	No charge
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$10 per visit
Chiropractic Services (up to 20 visits per Year)	$10 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit
Naturopathic Medicine	$10 per visit
Vision Services	**You pay**
Routine eye exam	$10
Vision hardware and optical Services	Balance after $200 allowance to use toward the purchase price of eyewear once within a two-calendar-year period.

Outside Service Area Benefit	20%. The annual benefit maximum is $1,250. Kaiser Permanente pays 80% up to $1,000 per year. You pay 100% thereafter. (In the U.S. only.)
Silver&Fit®	$0 for basic fitness center membership at participating centers.
Hearing Aids[2]	Not covered

[1] Refer to your Medical Benefits Chart for cost-sharing that does not apply to the out-of-pocket maximum.
[2] Your plan provider may need to provide a referral.
† Prior authorization may be required.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

Have questions?

- Please call Member Services at **1-877-221-8221 (**TTY **711**).
- 7 days a week, 8 a.m. to 8 p.m.

The benefit information provided is a brief summary, not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. If you receive Extra Help to pay for Medicare Part D prescription drug coverage, premiums and cost sharing will vary based on the level of Extra Help you receive. Please contact the plan for further details.

Summary of Medical Benefits

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

Member Services: 1-800-813-2000

Oregon **1/1/2022 - 12/31/2022**

Clackamas County **Group Number: 1183-066**

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible	
Self-only Deductible per Year (for a Family of one Member)	$1,400
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$1,400
Family Deductible per Year (for an entire Family)	$2,800
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$3,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$3,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$9,000
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0
Primary Care	$25
Specialty Care	20% Coinsurance after Deductible
Urgent Care	$25
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$20 generic / $40 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$40 generic / $80 preferred brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$5
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible

Hospital Services	**You pay**
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency services	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	20% Coinsurance
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible
Mental Health and Chemical Dependency Services	**You pay**
Outpatient Services	$25 per visit
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$10 per visit
Chiropractic Services (up to 20 visits per Year)	$10 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit
Naturopathic Medicine	$25 per visit
Vision Services	**You pay**
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	$25
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to $200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once in a two-Year period.

[1] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

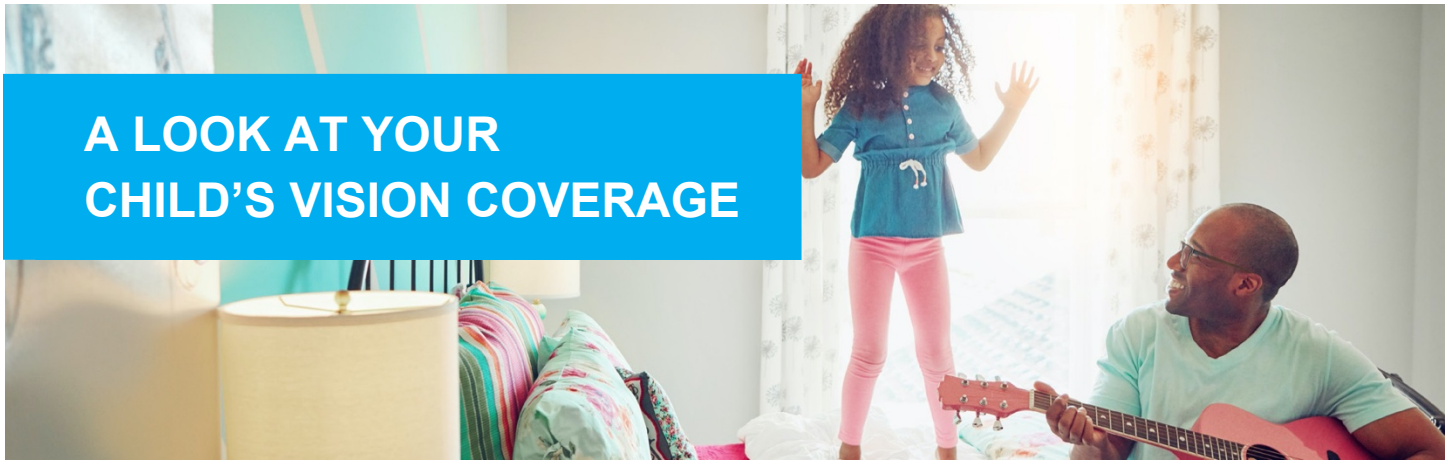
Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to **http://www.kp.org/plandocuments**

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

This is not a contract. This condensed summary of benefits 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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

EXHIBIT G

VSP – 2022 Benefit Summaries



A LOOK AT YOUR CHILD'S VISION COVERAGE

GET ACCESS TO THE BEST IN EYE CARE AND EYEWEAR WITH CLACKAMAS COUNTY (POA) AND VSP VISION CARE.

VSP® Vision Care

Enroll in VSP® Vision Care to get personalized eye care for your child from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Prefer to shop online? Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

COVERAGE FOR YOUR KIDS.

Many states require children to get an eye exam before kindergarten. Use your VSP benefits for a fully covered eye exam and frames the Otis & Piper™ Eyewear collection, or contacts to help them succeed in school.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your child's in-network coverage, find the pediatric eye doctor who's right for them, and discover savings with Exclusive Member Extras. At their appointment, tell them you have VSP—that's it!

Contact us: 800.877.7195 or vsp.com

YOUR VSP VISION BENEFITS SUMMARY

Clackamas County and VSP provide you with an affordable vision plan for your child(ren). POA Dependent Children 0-18

PROVIDER NETWORK:
VSP Choice

Benefit	Description	Copay	Frequency
	Coverage with a VSP Provider		
WellVision Exam	• Focuses on your child's eye health and overall wellness. Tests for childhood vision issues, like nearsightedness, lazy eye, and cross-eye.	$0	Every calendar year
PRESCRIPTION GLASSES			See frame and lenses
Frame	• 1 Frame from our exclusive Otis & Piper Eyewear Collection.	$0	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses.	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Impact-resistant lenses • Scratch-resistant coating • UV protection	$0 $0 $0	Every calendar year
Contacts (instead of Glasses)	• Contact lens exam and minimum three-month supply of contact lenses are fully covered. Ask your VSP network doctor which contacts qualify for your child's plan.	$0	Every calendar year
PRIMARY EYECARE	• Retinal screening for members with diabetes. • Additional exams and services related to diabetes, glaucoma, and age-related macular degeneration (AMD). • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$0 $20	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. You pay 50% of the provider's billed amount with an out of network provider. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Once your benefit is effective, visit **vsp.com** for details. Coverage information is subject to change. In the event of a conflict between information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM CLACKAMAS COUNTY (POA ADULTS AND CHILDREN OVER 19) AND VSP.

vsp Vision care for life

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

PREMIER PROGRAM

Like shopping online? Go to **eyeconic.com** and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST EYEWEAR

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

\+

UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Exhibit C
Page: 86

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY CLACKAMAS COUNTY (POA Adults and Children 19 and Over) and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
PRESCRIPTION GLASSES		$0	See frame and lenses
FRAME	• $150 featured frame brands allowance • $130 frame allowance • 20% savings on the amount over your allowance • $70 Costco® frame allowance		Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	$0	Every other calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every other calendar year
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every other calendar year
PRIMARY EYECARE℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

EXHIBIT H

Self-Funded Dental Plan Underwriting Calculation

Clackamas County - POA

Dental Projection for Jan 1, 2022 through Dec 31, 2022

		Incentive
1	***Most Recent 12 Months Ending***	***June 30, 2021***
2	Paid Claims for Entire 12-Month Period	$459,027
3	Stop Loss Credit	0
4	Historical Benefit Changes Adjustment	1.000
5	COVID Adjustment	$1,915
6	Adjusted Net Paid Claims during this Period	$460,942
7	Average Enrollment Setback (1) Month	293
8	Adjusted Paid Claims per Employee per Month (PEPM)	$131.10
9	Annual Trend	5.0%
10	Number of Months of Trend	19
11	Extended Trend Factor	1.080
12	**Projected Claims PEPM**	**$141.63**
13	Claims Fluctuation Margin	3.0%
14	**Projected Claims PEPM with Margin**	**$145.88**
15	Moda Administration Fee (1% increase)	$6.69
16	**Projected Total Cost PEPM**	**$152.57**
17	Current Budget, based on Current Rates	$143.90
18	**Needed Increase**	**6.0%**

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

EXHIBIT I

Delta Dental of Oregon – 2022 Contract Changes

DELTA DENTAL

Clackamas County (POA)
Oregon ASO Dental Plan Changes
Renewing January 1, 2022
(Preliminary draft as of (3/23/2021)

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2022. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
Additional changes may be required as a result of new federal rules or regulations	We will monitor for any changes to the ACA.		TBD

STATE REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
2021 Legislative Session	We will monitor the Oregon legislative session for any new requirements that could apply.	To be determined	TBD

BENEFIT CHANGE						
Accepted		Reference	Former Benefit	New Benefit	Explanation	Claims Impact*
Yes	No					
☑	☐	**Benefits and Limitations** Other Services	Not previously covered.	Occlusal guard is covered at 100%; no deductible up to a maximum of $250. Repairs and relines are not covered within initial 6 months of placement. After that 6-month period, repairs and relines are only covered once in every 12-month period.	Aligning with industry standard	0.4%

ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Pronoun changes	Removed binary pronouns. Replaced with either no pronoun ("the member," "the person," etc.) or they/their/them, to update language for gender-neutral inclusivity.
Benefits & Limitations	Added placement of device to facilitate eruption of impacted tooth.	This is not a benefit change. This service is currently covered as an orthodontia service and applies to the ortho lifetime maximum, but is not referenced in the handbook
Benefits and Limitations Restorative services - Basic	Added language that the plan denies post and core in addition to a crown unless less than half the coronal tooth structure remains.	Clarify existing limitation on post and core.
Enrolling Eligible Employees	Removed "Eligible employees can apply on the date of hire or the end of any required waiting period."	Unnecessary language
COBRA	Extending the length of COBRA coverage in the event of a disability	Updated language to clarify disability extension; disability must have started before the 61st day of the COBRA coverage period and the Social Security Administration determination must be made before the end of the initial 18-month COBRA coverage period

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

*Based on Delta Dental book of business.

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

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

Signature _____ **Date** 11/29/21

EXHIBIT J

Delta Dental of Oregon – 2022 Benefit Summaries

2022 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

Clackamas County

Effective January 1, 2022

Peace Officer's Association Incentive Plan

Calendar year costs	
Calendar year maximum, per member	$1,500
Calendar year deductible, per member	$0
Class I	
Periodic examinations / x-rays	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Prophylaxis (cleanings) / periodontal maintenance	
Sealants	
Space maintainers	
Topical application of fluoride	
Class II	
Restorative fillings	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Oral surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
Class III	
Crowns and other cast restorations	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Class IV	
Implants	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	
Athletic mouthguard	
Nightguards - occlusal guard	100% to a $250 maximum (deductible waived)
Orthodontia	
Lifetime maximum of $3,000 (Child Benefit)**	50%

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

**See your member handbook for specific orthodontia benefits.

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

How to use this dental plan

When you visit your dental provider, tell them you are a Delta Dental member.

When the member visits:

Delta Dental Premier Dentist:

Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:

Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class I services)

- **Diagnostic** Routine or comprehensive examinations or consultations are covered twice per year. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any five (5) year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance are covered once twice per year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per year for members under age 19. For members age 19 and older, topical application of fluoride is covered twice per year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.

Basic (Class II services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Restorative If a tooth can be restored with a material such as amalgam or composite filling, but another type of restoration is selected, covered expense will be limited to a composite. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.
- **Periodontic** Scaling and root planing is limited to once every 6 months.

Major (Class III & IV services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Athletic mouthguard** Covered at 50%, once in any 12-month period for members age 15 and under and once in any 2-year period age 16 and over. Over-the-counter athletic mouth guards are excluded.
- **Occlusal Guard** (nightguard) Covered at 100% once in a five year period, up to $250 maximum. Over-the-counter nightguards are excluded.

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 (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), 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 the teeth except for occlusal guards.
- 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.

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

888-217-2365 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 0569 (8/20)

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

EXHIBIT K

Carrier Information – A.M. Best Score

Insurance Company	A.M. Best Carrier #	A.M. Best FSR and, where applicable, FSR Modifier	A.M. Best FSR Effective Date
Kaiser Foundation Health Plan of the Northwest	N/A	Not Rated	N/A
Providence Health Plan	N/A	Not Rated	N/A
Vision Service Plan	064607	A-	05/14/2021
Oregon Dental Service	064364	B+u	10/08/2021
Unum Life Insurance Company of America	006256	A	06/10/2021
Metropolitan Life Insurance Company	006704	A+	12/17/2020
Standard Insurance Company	007069	A	11/04/2021
Cascade Centers	N/A	Not Insured	N/A
Navia	N/A	Not Insured	N/A
RGA Reinsurance Company	009080	A+	09/30/2021
HM Life Insurance Company	009063	A	09/17/2021
ReliaStar Life Insurance Company of New York	006157	A	01/14/2021

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