CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS

Study Session Worksheet

Presentation Date: 10/23/2012 **Approximate Start Time:** 3:30 PM **Approximate Length:** 30 minutes

Presentation Title: Benefits Renewals for 2013

Department: Employee Services

Presenters: Carolyn Williams, Benefits Manager
Mark Stotik, Labor & Employee Relations Manager

Other Invitees: N/A

WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?

DES is seeking formal Board approval to renew contracts with benefit providers for the 2013 plan year.

EXECUTIVE SUMMARY:

The Department of Employee Services and its employee benefits consultant, Mercer, have completed negotiations with the County's insurance carriers and third party administrators for the 2013 employee benefit plan renewals. In addition, the Benefits Review Committee made plan design changes to lower the rate of increase for the Providence medical plans. The County must confirm the renewals prior to November 1, 2012 to ensure coverage for the 2013 plan year.

See attached Renewal Report for detailed information on the 2013 renewals.

Medical & Dental

Preliminary renewals for the General County Providence plans were 9.2% for the Personal Option and 9.4% for the Open Option. The Benefits Review Committee approved plan changes to reduce the increase to 6% by raising the deductible on each plan from $250 to $500.

For the Peace Officers' Providence plans, the increases are 8.3% for the Personal Option and 8.4% for the Open Option. There were no plan changes made by the Peace Officers Benefits Committee.

The increase to the Kaiser Medical plans for both General County and Peace Officers is 7.7%. The Kaiser plans are less expensive than the Providence plans (about 12% less than General County plans and 17% less than the Peace Officers plans) so remain well below the cap established for the Providence plans.

Increases to the self-insured dental plans administered by ODS range from 7.8%-8.3%. The fully-insured Kaiser dental plan will increase by 9.8%.

Other Benefits

There were 0% increases to group term life insurance provided through Met Life and the fully-insured long-term disability coverage provided though Standard Insurance. For the self-insured short-term disability program, there will be a 12.5% increase in funding. This follows a 15.8% decrease in 2012.

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

The maximum contribution to the health care flexible spending account will be reduced from $5000 to $2500 as required under the Patient Protection & Affordable Care Act.

Nonrepresented Employee Cost Sharing

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

FINANCIAL IMPLICATIONS (current year and ongoing):

The estimated fiscal impact for the 2013 plan year is:

Medical:	$1,749,904
Dental:	249,917
STD	14,239
Total:	$2,014,060

LEGAL/POLICY REQUIREMENTS:

Employee benefits must be provided as required under the provision of the collective bargaining agreements.

PUBLIC/GOVERNMENTAL PARTICIPATION:

N/A

OPTIONS:

It is highly unlikely that the County would be able to negotiate any lower increases or find any other carrier willing to offer lower rates over a sustained period of time.

RECOMMENDATION:

1. Approve renewal contracts with Kaiser, Providence Health Plan, Oregon Dental Service, Metropolitan Life, Standard Insurance and Flex-Plan.
2. Pay 95% of the premiums for the medical coverage, and 100% of the premiums for dental, life and disability plans for nonrepresented employees.

ATTACHMENTS:

2013 Health and Welfare Benefit Plan Renewal Report

SUBMITTED BY:

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

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

CLACKAMAS COUNTY

NANCY DRURY
DIRECTOR

DEPARTMENT OF EMPLOYEE SERVICES

PUBLIC SERVICES BUILDING
2051 KAEN ROAD | OREGON CITY, OR 97045

SUMMARY OF 2013 BENEFIT PLAN RECOMMENDATIONS REQUIRING APPROVAL BY THE BOARD OF COUNTY COMMISSIONERS

	YES
2010 RENEWALS: Shall the County enter into contracts for 2013 with:	
Kaiser for the General County and Peace Officers plans?	___
Providence Health Plans for the General County and Peace Officers plans?	___
ODS Health Plans to administer dental claims? 1.9% administrative fee increase	___
Kaiser Dental for General County and Peace Officers insured plans?	___
Metropolitan Life Insurance Company for the General County and Peace Officers Basic Group Term Life Insurance Plan?	___
Standard Insurance Company for the General County and Peace Officers Long Term Disability Plan?	___
Flex Plan for Flexible Spending Account claims administration?	___
NONREPRESENTED EMPLOYEES:	YES
Medical: Shall the County pay 95% of the tiered premium?	___
Dental: Shall the County continue to pay 100% of the rate for the dental plans administered by ODS and Kaiser?	___
Life: Shall the County continue to pay 100% of the cost for the $150,000 coverage level?	___
Disability: Shall the County pay 100% of the premium for short and long term disability coverage?	___

This document will serve as the official statement of Board preliminary approval to enter into contracts and to establish nonrepresented employee cost sharing for the 2013 plan year. Contracts are in the process of being prepared by providers. When completed, they will be reviewed and approved by County Counsel prior to submittal to the Board of County Commissioners for final approval.

BOARD OF COUNTY COMMISSIONERS

_____ _____

Charlotte Lehan, Chair Date

_____

Recording Secretary

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MERCER

CONSULTING. OUTSOURCING. INVESTMENTS.

2013 HEALTH AND WELFARE BENEFIT PLAN RENEWAL REPORT

CLACKAMAS COUNTY

OCTOBER 17, 2012

MARSH & McLENNAN COMPANIES

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Summary

The General County and Peace Officers Association (POA) 2013 health and welfare benefit plans renewal decisions are outlined in this report. The Providence and Kaiser medical/ prescription drug plans had required contract changes. After reviewing several plan options, the Benefit Review Committee (BRC) elected to increase the common deductible for the Providence Open and Personal Option General County plans. The POA decided to keep their current benefits.

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

	Rates PEPM		
	2012	2013	% Change
Medical/Prescription/Vision Alternative Care Plans			
Providence Health Plan – General County [1]			
Personal Option 20/20/1200 $500 Common Deductible			
Employee Only	$569.06	$599.87	
Employee + Spouse	1,138.20	$1,199.82	
Employee + Children	1,024.30	$1,079.75	
Employee + Family	1,707.19	$1,799.62	
Composite	1,256.67	$1,324.71	**5.4%**
Open Option 15/10/30/2000 $500 Common Deductible			
Employee Only	$583.02	$615.56	
Employee + Spouse	1,166.12	$1,231.20	
Employee + Children	1,049.42	$1,107.99	
Employee + Family	1,749.07	$1,846.69	
Composite	1,251.01	$1,320.83	**5.6%**
Providence Health Plan – POA [1]			
Personal Option 15/0/1000			
Employee Only	$608.91	$659.42	
Employee + Spouse	1,217.89	1,318.93	
Employee + Children	1,096.02	1,186.95	
Employee + Family	1,826.73	1,978.27	
Composite	1,523.77	1,650.17	**8.3%**
Open Option 10/0/20/2000 $50 Common Deductible			
Employee Only	$602.89	$653.76	
Employee + Spouse	1,205.84	1,307.61	
Employee + Children	1,085.18	1,176.76	
Employee + Family	1,808.66	1,961.29	
Composite	1,446.07	1,568.11	**8.4%**
Kaiser Permanente HMO – General County (with hearing aids)			
Employee Only	$543.55	$585.13	
Employee + Spouse	1,087.10	1,170.26	
Employee + Children	978.39	1,053.23	
Employee + Family	1,630.64	1,755.39	
Composite	$1,127.15	$1,213.37	**7.7%**
Kaiser Permanente HMO – POA			
Employee Only	$541.51	$582.94	
Employee + Spouse	1,083.03	1,165.88	
Employee + Children	974.72	1,049.29	
Employee + Family	1,624.54	1,748.82	
Composite	1,203.71	1,295.79	**7.7%**

Providence Retirees - $1000 Deductible [1]			
Retiree Only	$493.68	$541.45	**9.7%**
Retiree + Spouse	987.41	1,082.98	
Retiree + Children	888.60	974.60	
Retiree + Family	1,481.03	1,624.36	
Kaiser Permanente Retirees – General County $1000 Deductible			
Retiree Only	$405.52	$439.64	**8.4%**
Retiree + Spouse	811.04	879.28	
Retiree + Children	729.94	791.35	
Retiree + Family	1,216.61	1,318.96	
Kaiser Permanente Retirees – POA $1000 Deductible			
Retiree Only	$405.54	$439.70	**8.4%**
Retiree + Spouse	811.08	879.39	
Retiree + Children	729.97	791.46	
Retiree + Family	1,216.66	1,319.14	
Kaiser Permanente Medicare Retirees			
Retiree Only	$334.62	$337.64	**0.9%**
Dental Plans			
Oregon Dental Service			
Administration	$5.91	$6.02	**1.9%**
Incentive Plan			
Employee Only	$70.00	$76.00	
Employee + Spouse	142.00	$153.00	
Employee + Children	100.00	$108.00	
Employee + Family	171.00	$185.00	
Composite	133.00	$144.00	**8.3%**
50% Plan – General County Only			
Employee Only	$33.00	$36.00	
Employee + Spouse	66.00	$71.00	
Employee + Children	46.00	$50.00	
Employee + Family	78.00	$84.00	
Composite	64.00	$69.00	**7.8%**
Preventive Plan – General County Only			
Employee Only	$67.00	$72.00	
Employee + Spouse	134.00	$145.00	
Employee + Children	96.00	$104.00	
Employee + Family	163.00	$176.00	
Composite	126.00	$136.00	**7.9%**
Kaiser Permanente			
Employee Only	$76.13	$83.56	
Employee + Spouse	150.74	165.45	
Employee + Children	105.06	115.31	
Employee + Family	180.43	198.04	
General County Composite	139.89	153.54	**9.8%**

Life and AD&D – MetLife			
Basic Life (Rate per $1,000 benefit)			
Nonrepresented – General County Only	$0.264	$0.264	**0.0%**
Represented – General County and POA	0.246	0.246	**0.0%**
Group Universal Life	Age rated	Age rated	**0.0%**
Dependent Life per Employee (Rate per Family)			
$5,000 per Dependent – General County	$2.66	$2.66	**0.0%**
$2,000 per Dependent – POA	0.42	0.42	**0.0%**
Voluntary AD&D – General County Only (Rate per $1,000 benefit)			
Employee Only	$0.050	$0.050	**0.0%**
Employee and Family	0.075	0.075	**0.0%**
LTD – The Standard Insurance			
Self-Insured – General County			
Funding Rate (Rate per $100 covered salary)	$0.16	$0.18	**12.5%**
General Fee (Rate per Employee)	0.25	0.32	**28.0%**
New Claim Fee (Rate per Claim)	250.00	334.00	**33.6%**
Open Claim Fee (Rate per Claim)	12.00	16.00	**33.3%**
Fully Insured – General County			
Base Plan (Rate per $100 Covered Salary)	$0.38	$0.38	**0.0%**
Buy-Up Plan (Rate per $100 Covered Salary)	0.38	0.38	**0.0%**
Fully Insured – Peace Officers			
Base Plan (Rate per $100 Covered Salary)	$0.35	$0.35	**0.0%**
Buy-Up Plan (Rate per $100 Covered Salary)	0.39	0.39	**0.0%**
Employee Assistance Plan (EAP) – The Standard Insurance – General County Only			
General Fee per Employee	$0.25	$0.10	**-60.0%**
Flexible Spending Account – Flex Plan – General County Only			
Monthly Fee per Participant	$5.00	$5.00	**0.0%**
LTC – UnumProvident – General County Only			
Monthly Rate per Participant	Age rated	Age rated	**0.0%**

[1]*Rates include the BRC-approved and the standard 2013 contract changes.*

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Medical/Prescription Drug/Vision/Alternative Care Plans

Providence Health Plan

General County

The preliminary proposed 2013 rate increase was 11.1% and 10.9%, depending on the plan, over the 2012 rates. After updating the renewal calculation with June claims experience, Providence reduced the 2013 renewal increase to 9.4% and 9.2%.

The Benefit Review Committee (BRC) requested Providence provide renewal options that would lower the renewal to a 5, 6, 7 or 8% increase over the 2012 rates. The BRC elected the plan change to reduce the renewal to a 6% increase; that change is raising the common deductible from $250 to $500 for both the Open and Personal Option plans.

The County renewed the medical, vision, and prescription drug plans with Providence effective January 1, 2013.

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

Exhibit B contains the standard 2013 contract changes proposed by Providence. These changes were accepted and will take affect January 1, 2013.

See **Exhibit C** for the Providence 2013 General County benefit summaries.

The 2013 premium rates, which include the required contract changes for the plans, are as follows:

Personal Option 20/20/1200 $500 Common Deductible

Rates per Employee per Month					
	Medical	Rx $15/$30	Vision $400	Alt Care $20/$1,500	Total
Actives, Job Share, COBRA[1], & Early Retiree					
Employee Only	$507.87	$75.63	$8.46	$7.91	$599.87
Employee + Spouse	1,015.81	151.27	16.92	15.82	1,199.82
Employee + Children	914.15	136.13	15.23	14.24	1,079.75
Employee + Family	1,523.62	226.89	25.38	23.73	1,799.62
Composite					1,324.71

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

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

Rates per Employee per Month						
	Medical	Rx $15/$30	Vision $400	Alt Care $15 / $1,500	Hearing Aids $1,500	Total
Actives, Job Share, COBRA[1], & Early Retiree						
Employee Only	$519.51	$75.63	$8.46	$8.83	$3.13	$615.56
Employee + Spouse	1,039.09	151.27	16.92	17.66	6.26	1,231.20
Employee + Children	935.11	136.13	15.23	15.89	5.63	1,107.99
Employee + Family	1,558.54	226.89	25.38	26.49	9.39	1,846.69
Composite						$1,320.83

Peace Officers

The preliminary proposed 2013 rate increase was 10.2% and 10.1% over the 2012 rates. After the projection was updated with June claims experience, Providence reduced the 2013 renewal to 8.4 and 8.3%.

The County renewed the medical, vision, and prescription drug plans with Providence effective January 1, 2013.

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

The standard 2013 contract changes in **Exhibit B** also apply to the POA plans; see explanation under General County.

See **Exhibit C** for the Providence 2013 POA benefit summaries.

The 2013 premium rates, which include the required contract changes for the plans, are as follows:

Personal Option 15/0/1000

Rates per Employee per Month					
	Medical	Rx $10/$15	Vision $200	Chiro $10/$1,500	Total
Actives, Job Share, COBRA[1], & Early Retiree					
Employee Only	$559.45	$88.56	$6.49	$4.92	$659.42
Employee + Spouse	1,118.98	177.13	12.98	9.84	1,318.93
Employee + Children	1007.00	159.41	11.68	8.86	1,186.95
Employee + Family	1,678.36	265.68	19.47	14.76	1,978.27
Composite					1,650.17

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

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

Rates per Employee per Month					
	Medical	Rx $10/$15	Vision $200	Chiro $10/$1,500	Total
Actives, Job Share, COBRA[1], & Early Retiree					
Employee Only	$553.79	$88.56	$6.49	$4.92	$653.76
Employee + Spouse	1107.66	177.13	12.98	9.84	1,307.61
Employee + Children	996.81	159.41	11.68	8.86	1,176.76
Employee + Family	1,661.38	265.68	19.47	14.76	1,961.29
Composite					1,568.11

Retirees – General County and Peace Officers

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

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

Alternatively, the County also offers a $1,000 deductible plan for early retirees and COBRA participants. The County accepted Providence's proposed rate increase of 9.7%. Outlined in the table below are the 2013 premium rates for the current $1,000 Deductible plan.

Exhibit B contains the standard 2013 contract changes proposed by Providence.

See **Exhibit C** for the Providence 2013 early retiree benefit summaries.

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

Rates Per Retiree Per Month			
	Medical	Rx $10/50%/$1,000	Total
COBRA[1], & Early Retiree			
Employee Only	$474.95	$66.50	$541.45
Employee + Spouse	949.97	133.01	1,082.98
Employee + Children	854.90	119.70	974.60
Employee + Family	1,424.86	199.50	1,624.36

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

Medicare-Eligible retirees (age 65 and older) are eligible for the Medicare Group Extra plan and Supplement Plan F.

Medicare Extra and Supplement Plans

Medicare Group Extra With Prescription Drug	$287.33
Medical Supplement Plan F Total	553.24
Medical	351.51
Prescription Drug	201.73

Kaiser Permanente

General County and Peace Officers

Kaiser proposed an overall 7.7% increase to the 2012 medical premium rates. The BRC and POA did not elect to make benefit changes to this plan. The County renewed the medical, vision, and prescription drug plans with Kaiser Permanente effective January 1, 2013.

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

Exhibit E contains the 2013 contract changes provided by Kaiser. None of the changes that increased member cost-sharing were accepted. All others will take effect January 1, 2013.

See **Exhibit F** for the Kaiser 2013 benefit summaries.

The 2013 premium rates, which include the required contract changes for the plans, are as follows:

Medical/Prescription Drug/Vision Plans

Rates per Employee per Month	
General County	
Employee Only	$585.13
Employee + Spouse	1,170.26
Employee + Children	1,053.23
Employee + Family	1,755.39
Composite	1,213.37
Peace Officers Association	
Employee Only	$582.94
Employee + Spouse	1,165.88
Employee + Children	1,049.29
Employee + Family	1,748.82
Composite	1,295.79

Retirees – General County and Peace Officers

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a $1,000 deductible plan for early retirees and COBRA participants. The proposed rate increase of 8.4% was accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. The 2013 early retiree and Medicare-eligible rates are outlined below.

Exhibit E contains the 2013 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2013 benefit summaries.

Rates Per Retiree Per Month	
$1,000 Deductible Plan COBRA[1] and Early Retirees	
General County	
Employee Only	$439.64
Employee + Spouse	879.28
Employee + Children	791.35
Employee + Family	1,318.96
Peace Officers Association	
Employee Only	$439.70
Employee + Spouse	879.39
Employee + Children	791.46
Employee + Family	1,319.14
Medicare (Parts A, B and D)	
1 on Medicare	$337.64
2 on Medicare	675.28

Dental Plans

Oregon Dental Service

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

The County is entering the second year of a two-year rate guarantee. The administration fees increased 1.9% for 2013; the fee is listed below:

Rates per Employee per Month	
Administration fee	$6.02

The County renewed the dental administration services with ODS effective January 1, 2013.

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

Exhibit I contains the ODS standard contract changes for 2013. The General County and the BRC have accepted all ODS's proposed administrative contract changes. The POA plan will have the same changes as the General County. These changes will be effective January 1, 2013.

See **Exhibit H** for the 2013 ODS benefit summaries.

Underwriting

Mercer's estimated 2013 funding increase of 7.9% for the self-insured dental plans is projected by the underwriting methodology outlined below. **Exhibit I** includes the underwriting calculation.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2011, through June 30, 2012. An annual trend factor of 6.0%, an IBNR reserve factor of 10%, and 0% margin were used to project 2013 required funding.

Dental Plans[1]	
Projection Period	July 2011 – June 2012
Funding	
Paid Claims	$2,140,209
Required Increase in Reserve	16,201
Incurred Claims	$2,156,410
Trend (18 months)	196,233
Projected Incurred Claims	$2,352,643
ODS Administration	106,801
Required Income	$2,459,444
Required Change	**7.9%**

Mercer recommended and the County accepted the 2013 funding rates listed below.

Self-Funded Dental Plans

Budgeting Rates per Employee per Month	
Incentive Plan – General County and POA	
Employee Only	$76.00
Employee + Spouse	153.00
Employee + Children	108.00
Employee + Family	185.00
Composite	144.00
50% Plan – General County Only	
Employee Only	$36.00
Employee + Spouse	71.00
Employee + Children	50.00
Employee + Family	84.00
Composite	69.00

[1] The self-funded dental projections were based on a combination of General County and POA claims experience.

Preventive Plan – General County Only	
Employee Only	$72.00
Employee + Spouse	145.00
Employee + Children	104.00
Employee + Family	176.00
Composite	136.00

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees – General County and POA. Kaiser proposed a 9.8% increase to the 2012 premium rates. The BRC and POA did not make any benefit changes for 2013. The County renewed the dental plan with Kaiser Permanente effective January 1, 2013.

Exhibit E contains the 2013 standard contract changes provided by Kaiser, which will be effective January 1, 2013.

See **Exhibit F** for the Kaiser 2013 benefit summaries.

The 2013 premium rates are as follows:

Dental Plan

Rates per Employee per Month	
Employee Only	$83.56
Employee + Spouse	165.45
Employee + Children	115.31
Employee + Family	198.04
Composite	153.54

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. The current rates will be extended through December 31, 2013. The County renewed the plans with MetLife effective January 1, 2013, with no change in benefits.

A summary of the rates effective January 1, 2013, through December 31, 2013, are as follows:

General County

Basic Life	
Nonrepresented Employees	$0.264/$1,000
Represented Employees	$0.246/$1,000
Dependent Life	
$5,000 per spouse/domestic partner or child	$2.66 PEPM
Voluntary Accidental Death and Dismemberment	
Employee	$0.050/$1,000
Employee and Family (spouse/domestic partner or child)	$0.075/$1,000

Peace Officers

Basic Life	**$0.246/$1,000**
Dependent Life	
$2,000 per spouse/domestic partner or child	$0.42 PEPM

General County

Group Universal Life (Rates Per $1,000)		
Age	**Non-Smoker Rate**	**Smoker Rate**
< 30	$0.055	$0.082
30-34	0.061	0.093
35-39	0.078	0.128
40-44	0.120	0.186
45-49	0.205	0.279
50-54	0.337	0.413
55-59	0.530	0.648
60-64	0.801	0.996
65-69	1.483	1.586
70-74	2.482	2.482

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

Coverage Amount	**$2,000**	**$4,000**	**$6,000**	**$8,000**	**$10,000**
Monthly Rate	$0.148	$0.296	$0.444	$0.592	$0.74

Long Term Disability Insurance

The Standard

The County offers three LTD plans through Standard as follows:

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

- **Buy-up LTD Plans**
  - **General County.** This plan offers General County employees the option of buying additional disability coverage, equal to 60% of the next $5,000 of monthly predisability earnings above $3,333 up to a maximum of $8,333.
  - **Peace Officers.** This plan offers POA employees the option of buying additional disability coverage, equal to 60% of the next $6,667 of monthly predisability earnings above $3,333 up to a maximum of $10,000.

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

The benefits will remain unchanged for the 2013 plan year.

Fees and Premium Rates

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

The fees for self-funded administration will increase. The prior rates had remained in force for 18 years. This increase will help the County move closer to Standard's actual administrative costs for this plan. The fully insured LTD rates (Base and Buy-up) for the General County and Peace Officers will remain the same.

The 2013 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	$0.18 per $100 covered payroll
Administration Fees	
General	$0.32 PEPM
New Claim	$334 per claim
Open Claim	$16 per open claim at month end
Incidental	As incurred
Insured Plan	
Base – General County	$0.38/$100
Buy-Up – General County	$0.38/$100
Base – Peace Officers	$0.35/$100
Buy-Up – Peace Officers	$0.39/$100

Employee Assistance Plan

The Standard

The County also purchases an Employee Assistance Program (EAP) from Standard for the General County employees. The rate will decrease to $0.10 per member per month.

Flexible Spending Account Administrator

Flex-Plan Services

The County uses Flex-Plan Services to provide FSA plans, which are available only to General County employees. Flex-Plan proposed a rate hold for the 2013 plan year. The County renewed these services with Flex-Plan effective January 1, 2013.

The Health Care Flexible spending annual limit will be lowered from $5,000 to $2,500 as mandated by PPACA, effective January 1, 2013.

The 2013 fees remain the same as the 2012 fees, as follows:

Fees per Participant per Month	
Health Care FSA	$5.00
Dependent Care FSA	5.00

Long Term Care Insurance

Unum

Unum insures the voluntary long term care (LTC) coverage for General County employees. The 2013 rates remain unchanged and are age rated. The LTC rates have not changed since the inception of the plan January 1, 2000.

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Employee Contributions

General County

The collective bargaining agreements have not been ratified. The description below is based on the most recent offer by the County (October 2012). For represented employees, the County will pay 95% of the renewal composite medical/prescription/vision rate up to a capped composite amount. Nonrepresented employees pay 5% of the tiered premium rate, and the County pays the remaining 95%.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
NONREPRESENTED				
Providence Personal Option				
Employer	569.88	1,139.83	1,025.76	1,709.64
Employee	29.99	59.99	53.99	89.98
Providence Open Option				
Employer	584.78	1,169.64	1,052.60	1,754.36
Employee	30.78	61.56	55.39	92.33
Kaiser				
Employer	555.87	1,111.75	1,000.57	1,667.62
Employee	29.26	58.51	52.66	87.77
Medical Opt Out				
Cash Back	62.00	123.00	111.00	185.00
REPRESENTED				
Providence Personal Option				
Employer	533.63	1,133.58	1,013.51	1,733.38
Employee	66.24	66.24	66.24	66.24
Providence Open Option				
Employer	549.52	1,165.16	1,041.95	1,780.65
Employee	66.04	66.04	66.04	66.04
Kaiser				
Employer	524.46	1,109.59	992.56	1,694.72
Employee	60.67	60.67	60.67	60.67
Medical Opt Out				
Cash Back	138.00	138.00	138.00	138.00

There is no employee contribution for dental coverage. The cash back for General County employees enrolled in the ODS 50 percent plan is as follows:

Dental – 50% Plan	Employee Only	Employee + Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
NONREPRESENTED				
Employee Cash Back	37.00	73.00	50.00	88.00
REPRESENTED				
Employee Cash Back	65.00	65.00	65.00	65.00

Peace Officers

The collective bargaining agreement has not been ratified. Based on the County's most recent offer (September 2012), the County pays 95% of the premium for the Providence medical plans, and the employee pays 5% of the premium costs. The County pays 100% of the premium for employees enrolled in the Kaiser medical plan.

	Employee Only	Employee + Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Providence Personal Option				
Employer	576.91	1,236.42	1,104.44	1,895.76
Employee	82.51	82.51	82.51	82.51
Providence Open Option				
Employer	575.35	1,229.20	1,098.35	1,882.88
Employee	78.41	78.41	78.41	78.41
Kaiser				
Employer	582.94	1,165.88	1,049.29	1,748.82
Employee	0.00	0.00	0.00	0.00

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Exhibits

- Exhibit A – Providence Health Plans Medical Underwriting
- Exhibit B – Providence Health Plans 2013 Contract Changes
- Exhibit C – Providence Health Plans Benefit Summaries
- Exhibit D – Kaiser Permanente Medical Underwriting
- Exhibit E – Kaiser Permanente 2013 Contract Changes
- Exhibit F – Kaiser Permanente Benefit Summaries
- Exhibit G – ODS 2013 Contract Changes
- Exhibit H – ODS Benefit Summaries
- Exhibit I – Self-funded Dental Plan Underwriting Calculation

EXHIBIT A

Providence Health Plans Medical Underwriting

Account:	CLACKAMAS COUNTY - ACTIVE/EARLY RETIREES - UPDATE		
Group Number:	100112		
Account Executive:	D. MINER		
Agent Name:	JAN LONG		
Effective Date:	1/1/2013 - 12/31/2013		
Product(s):	PE 20/20/1200 250D-CUST	PENN 20/20/1200 250D-CUST	
	Rx-$15/$30-CUST	Rx-$15/$30-CUST	
	VIS 400	VIS 400	
	ALT $20/$1500 w/MA-CUST	ALT $20/$1500 w/MA-CUST	

Agent commission has been removed from the rates

Rates include domestic partner coverage
Rates reflect a tandem offering
Rates include coverage for elective sterilizations
Rates include coverage for termination of pregnancy
This rate quote includes reform adjustments that are required for plan years effective 9/23/2010 and later as outlined in The Patient Protection and Affordable Care Act.

Current Paid Claims Perio 7/1/2011 - 6/30/2012						
Experience Rate Exhibit	Capitation	Medical	Pharmacy	Vision	Chiro./ Alt .Care	Total
Paid Claims/Capitation	$784,238	$14,833,092	$2,582,640	$247,867	$221,223	$18,539,260
Pharmacy Rebate	n/a	n/a	-$48,124	n/a	n/a	-$48,124
Benefit Adjustments	-$12,767	-$262,000	-$114,797	$31,079	$18,339	-$390,166
Adjusted Non-Pooled Claims	$691,471	$14,551,093	$2,369,919	$258,937	$239,561	$18,110,982
Ending Reserve	n/a	$1,224,346	$35,365	$27,249	$0	
Beginning Reserve	n/a	$1,255,732	-$70,326	-$12,607	$0	
Incurred Claims	$691,471	$14,519,706	$2,334,978	$273,579	$239,561	$18,059,296
Pooled Claims Credit ($150K)	n/a	-$257,902	$0	$0	n/a	
Net Pooled Claims	$691,471	$14,261,805	$2,334,978	$273,579	$239,561	$17,801,395
Annual Trend	8.90%	8.90%	5.60%	2.06%	10.00%	8.38%
Months of Trend	18.0	18.0	18.0	18.0	18.0	
Trend Factor	1.1364	1.1364	1.0852	1.0301	1.1537	
Trended Incurred Claims	$785,607	$16,207,510	$2,533,837	$281,827	$276,380	$20,085,361
Pooling Charge	n/a	$656,052	$0	$0	n/a	
Trended Incurred Claims adjusted for Pooling		$17,649,369	$2,533,837	$281,827	$276,380	$20,741,413
Administration		$1,523,812	$243,857	$26,692	$28,372	$1,824,733
Portability Adjustment		$267,368	$38,205	n/a	n/a	$305,573
OMP Assessment		$257,676	n/a	n/a	n/a	$257,676
Patient-Centered Outcome Research Institute Fee		$7,910	n/a	n/a	n/a	
Commission None		$0	$0	$0	$0	$0
Projected Revenue Requirement		$19,706,136	$2,815,899	$310,519	$304,752	$23,137,306
Member Months		47,367	47,367	46,702	46,702	47,367
Projected Revenue Requirement (current 12 mos.)		$416.03	$59.45	$6.65	$6.53	$488.66
Factor to adjust Proj Rev Req (curr 12 mos) to new product		1.000	1.000	1.000	1.000	
Projected Revenue Req (curr 12 mos) adjusted to new product		$416.03	$59.45	$6.65	$6.53	$488.66
Projected Revenue Requirement (current 12 mos.)		$416.03	$59.45	$6.65	$6.53	$488.66
Projected Revenue Requirement (prior 12 mos.)		$430.84	$64.29	$6.34	$6.70	$508.17
Projected Revenue Requirement (demographics)		$331.40	$49.50	$4.99	$6.22	$392.12
Credibility Factor (current 12 mos.)		100.00%	100.00%	100.00%	0.00%	100.00%
Credibility Factor (prior 12 mos.)		0.00%	0.00%	0.00%	0.00%	0.00%
Credibility Factor (demographics)		0.00%	0.00%	0.00%	100.00%	0.00%
Blended Revenue Requirement PMPM		$416.03	$59.45	$6.65	$6.22	$488.35
Blended Revenue Requirement PMPM modified for Refunding Agreement		$422.27	$60.34	$6.75	$6.31	$495.68
Blended Revenue Requirement PMPM - adjusted for Oregon Premium Tax		$426.54	$60.95	$6.82	$6.38	$500.68

Current Enrollment:

	Subscribers	Members	Mix	Contract Size	Rate Ratio	Mix x Size	Mix x Ratio
EMPLOYEE	351	351	23.5%	1.000	1.000	0.235	0.235
EE+SPOUSE	403	806	27.0%	2.000	2.000	0.539	0.540
EE+CHILD(REN)	146	414	9.8%	2.836	1.800	0.277	0.176
EE+FAMILY	594	2,402	39.8%	4.044	3.000	1.608	1.193
Total	1,494	3,973	100.0%			2.659	2.143
					Single Rate Multiplier		1.241

Renewal Rates:

	Medical	Pharmacy	Vision	Chiro	Total
EMPLOYEE	$529.26	$75.63	$8.46	$7.91	$621.26
EE+SPOUSE	$1,058.56	$151.27	$16.92	$15.82	$1,242.60
EE+CHILD(REN)	$962.66	$136.13	$15.23	$14.24	$1,118.26
EE+FAMILY	$1,587.79	$226.89	$25.36	$23.73	$1,863.79

Account:	CLACKAMAS COUNTY - ACTIVE/EARLY RETIREES - UPDATE		
Group Number:	100112		
Account Executive:	D. MINER		
Agent Name:	JAN LONG		
Effective Date:	1/1/2013	-	12/31/2013
Product(s):	PE 20/20/1200 250D-CUST		PENN 20/20/1200 250D-CUST
	Rx-$15/$30-CUST		Rx-$15/$30-CUST
	VIS-100		VIS-100
	ALT $20/$1500 w/MA-CUST		ALT $20/$1500 w/MA-CUST

Agent commission has been removed from the rates

Rates include domestic partner coverage
Rates reflect a tandem offering
Rates include coverage for elective sterilizations
Rates include coverage for termination of pregnancy

This rate quote includes reform adjustments that are required for plan years effective 9/23/2010 and later as outlined in The Patient Protection and Affordable Care Act.

Prior Paid Claims Period	7/1/2010		6/30/2011			Chiro	
Experience Rate Exhibit		Capitation	Medical	Pharmacy	Vision	Alt. Care	Total
Paid Claims Period	201007	201106					
Paid Claims/Capitation		$595,802	$13,580,775	$2,458,615	$248,012	$180,987	$17,072,191
Pharmacy Rebate		n/a	n/a	-$46,904	n/a	n/a	-$46,904
Benefit Adjustments		-$10,393	-$203,745	-$112,729	$12,195	$36,426	-$278,245
Adjusted Non-Pooled Claims		$585,409	$13,377,031	$2,298,983	$258,208	$217,413	$16,747,042
Ending Reserve		n/a	$1,255,732	$70,326	$12,607	$0	
Beginning Reserve		n/a	-$1,157,745	-$53,084	-$22,140	$0	
Incurred Claims		$585,409	$13,475,018	$2,326,225	$248,674	$217,413	$16,852,738
Pooled Claims Credit ($150K)		n/a	-$153,236	$0	$0	n/a	
Net Pooled Claims		$585,409	$13,321,782	$2,326,225	$248,674	$217,413	$16,699,502
Annual Trend		8.00%	8.00%	5.60%	2.00%	10.00%	7.61%
Months of Trend		30	30	30	30	30	
Trend Factor		1.2122	1.2122	1.1459	1.0508	1.2691	
Trended Incurred Claims		$709,608	$16,148,111	$2,665,701	$261,295	$275,910	$20,060,625
Pooling Charge		n/a	$638,267	$0	$0	n/a	
Trended Incurred Claims adjusted for Pooling			$17,495,986	$2,665,701	$261,295	$275,910	$20,698,892
Administration			$1,830,568	$256,547	$26,602	$28,324	$2,142,041
Portability Adjustment			$269,377	$40,193	n/a	n/a	$309,570
OMIP Assessment			$250,691	n/a	n/a	n/a	$250,691
Patient-Centered Outcome Research Institute Fee			$7,696	n/a	n/a	n/a	
Commission	None		$0	$0	$0	$0	$0
Projected Revenue Requirement			$19,854,318	$2,962,442	$287,897	$304,234	$23,408,890
Member Months			46,083	46,083	45,397	45,397	46,083
Projected Revenue Requirement (prior 12 mos.)			$430.84	$64.29	$6.34	$6.70	$508.17
Factor to adjust Proj Rev Req (prior 12 mos) to new product			1.000	1.000	1.000	1.000	
Projected Revenue Req (prior 12 mos) adjusted to new product			$430.84	$64.29	$6.34	$6.70	$508.17

EXHIBIT B

Providence Health Plans 2012 Contract Changes

PROVIDENCE Health Plan

Oregon group contract changes, effective Aug. 1, 2012

Personal Option & Open Option (Actual updates to the contracts will take place at Clackamas County's 2013 renewal.)

Contract component	Description of change	Admin change	Clarification change	Benefit change
Federal/state reform requirements				
Family Planning Services Applies to all medical handbooks (PPACA)	Oral contraceptives, IUDs and diaphragms are covered in full under the medical benefit when obtained from a participating provider.	N	N	Y
Federal Medical Loss Ratio Applies to all medical handbooks (PPACA)	In accordance with the Federal Medical Loss Ratio requirements, premium rebates may be issued directly to employers by Providence Health Plan. Should this occur, the employer will be responsible for distributing this rebate to subscribers and shall assist us in documenting compliance.	Y	N	N
Voluntary Sterilization Applies to all medical handbooks and benefit summaries (PPACA)	Voluntary sterilization for women only (tubal ligation) is now covered under the medical benefit. Coverage for male vasectomy services is available, for large groups only, when purchased as an endorsement.	N	N	Y

1 Aug. 1, 2012, Oregon group contract changes – Providence Health Plan (Clackamas County 2013 Renewal Proposal, July 2, 2012)

Contract component	Description of change	Admin change	Clarification change	Benefit change
Administrative change				
Continuation of Coverage for Surviving Spouses Applies to all medical handbooks	For groups with 20 or more employees, the state-mandated continuation of coverage will terminate upon eligibility for other group coverage.	N	Y	N
Genetic Testing Applies to all medical handbooks	Genetic studies and counseling are covered if necessary to make a medical diagnosis or to aid in treatment planning; prior authorization is required.	Y	N	N
Clarification change				
Emergency Care Inpatient Admission Applies to all medical handbooks and benefit summaries	If admitted to the hospital through the emergency room, the emergency services copayment/coinsurance is not applied; all services are subject to the inpatient services benefit shown in the benefit summary.	N	Y	N

Women's Preventive Services

The services listed below will be covered in full, In-Plan, with no cost share to the member. For members with Out-of-Plan benefits, the cost share applicable to the service will apply. In all instances, oral contraceptives must be purchased from a participating pharmacy.

- Medical exams and consultation for family planning
- Intrauterine device (IUD)
  - Insertion and removal
  - Professional fees and the device
- Diaphragms
  - Whether obtained at a participating provider office, or participating pharmacy
- Cervical Caps
- Depo-Provera
- Removal of Norplant
- Tubal ligation
  - Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience Providence Health & Services facilities do not offer these services.
  - For members with Out-of-Plan benefits, if they utilize non-participating providers for this service the Out-of-Plan surgical benefits will apply.
- Oral Contraceptives: see the following list

Formulary generic contraceptives		
Amethyst	Apri	Aranelle
Aviane	Balziva	Brevicon
Cryselle	Enpresse	Gianvi
Jolessa	Junel FE	Junel
Karvia	Kelnor	Leena
Levora	Low-Ogestrel	Lutera
Medroxyprogesterone inj	Microgestin FE	Microgestin
Mononessa	Necon	Norinyl
Nortrel	Ocella	Ogestrel
Portia	Quasense	Reclipsen
Tri-Legest	Trinessa	Tri-Previfem
Tri-Sprintec	Zovia	
Formulary brand contraceptives		
Depo-Provera SQ (INJ)	Loestrin 24 FE	NuvaRing
Ortho Evra	Ortho Tri-Cyclen Lo	
Over-the-counter (OTC) Products		
Encare (Vag. Supp)	Female Condom (Multiple Manu.)	Gynol II (Contraceptive Jelly)
Today (Contraceptive Sponge)	VCF (Contraceptive Film & Foam)	

Additional notes:

- PHP will cover formulary items in full, drugs that are non-formulary will have member cost share.
- If member chooses to get a brand when there is a generic available member cost share will apply.
- This list is subject to change, other drugs could be added to formulary or PHP could decide to make a formulary change (add or remove a drug from formulary status). If something is removed from our formulary we do provide notification to the members and provide options.

EXHIBIT C

Providence Health Plans Benefit Summaries

Your Benefit Summary
Personal Option Plan
Clackamas County - General County Employees

PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum (after deductible)	Calendar Year Deductible
$20	20% coinsurance (after deductible)	$1,200 per person $3,600 per family (3 or more)	$500 per person $1,500 per family (3 or more)

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

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan only provides benefits for medically necessary services when provided by a participating physician or provider.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Personal Option Plan Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services:
✓ No deductible needs to be met prior to receiving this benefit.	Copay or Coinsurance (from participating providers only)
Physician / Provider Services	
• Office visits	$20 / visit✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓
• Vision and hearing screenings for children under 18	Covered in full✓
• Routine immunizations; shots	Covered in full✓
• Maternity services; pre- and postnatal visits	$150 / delivery✓
• Allergy shots; serums; injectable medications	$20 / visit✓
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full✓
• Mammograms	Covered in full✓
Hospital Services	
• Inpatient care	20%
• Observation care	20%
• Maternity care	20%
• Routine newborn nursery care	20%✓
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Outpatient Diagnostic Services	
• X-ray; lab services	Covered in full✓
• Imaging services (such as PET, CT, MRI)	Covered in full✓
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year; deductible waived)	20%✓
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$20 / visit✓
• Emergency medical transportation	20%

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Other Covered Services	
• Colonoscopy, sigmoidoscopy	Covered in full✓
• Outpatient rehabilitative services (30 visits per calendar year)	$20 / visit✓
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Home health care	20%
• Hospice care	Covered in full✓
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)	
-Generic drugs	$10✓
-Formulary brand-name drugs	$50✓
-Non-formulary brand-name drugs	$100✓
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)	
• Inpatient and day treatment services	20%
• Residential services	20%
• Outpatient provider visits	$20 / visit✓

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

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

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

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

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

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

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

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

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

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

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

Alternative Care Plan

Clackamas County - General County Employees on a Personal Option Plan

PROVIDENCE Health Plan

Copay
$20

Maximum Calendar Year Benefit
$1,500 per member

Important information about your plan

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

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.
- With this benefit you have access to four of the most popular types of alternative health care providers: acupuncturists, chiropractors, massage therapists and naturopaths.

About your alternative care benefit

This plan covers alternative care services when they are:

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

What you need to know before you use this benefit

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

Using non-participating providers

- In rare circumstances, our national network may not have a participating provider in your area. If this occurs, please contact our authorizing agent at 1-800-678-9133. If our authorizing agent is not able to locate a participating provider within a reasonable distance, authorization for use of a non-participating provider will be provided.
- Non-participating providers must be licensed in the state in which they are practicing and must practice within the scope of their license.
- Payment to non-participating providers is based upon Usual, Customary, and Reasonable (UCR) charges. Amounts in excess of UCR are your responsibility.
- Claims should be submitted to American Specialty Health Network, 777 Front Street, San Diego, CA 92101.
- In some cases, you may need to pay the non-participating provider directly for the full cost of the services received and submit your itemized billing to our authorizing agent for reimbursement.
- You are responsible for obtaining prior authorization from our authorizing agent when receiving services from non-participating providers.

Acupuncture covered services

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

Chiropractic covered services

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

Naturopathy covered services

- Services must be provided within a course of treatment that includes both (a) natural treatment methods, modalities, nutritional advice, recommendation of homeopathic protocols, and (b) excludes prescribing prescription or over-the-counter drugs, surgery, or invasive therapeutic procedures.
- Office visits/consultations, therapeutic procedures and other services provided in various combinations.
- Physical therapy which may include ultrasound, hot packs, cold packs, manual, mechanical, or electrical stimulation of the muscles, rehabilitative exercise.
- Related diagnostic X-rays and laboratory services.
- All naturopathic services must be approved by Providence Health Plan or its authorizing agent as medically necessary.

Massage therapy covered services

- Short-term rehabilitative therapy.

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

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

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

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

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

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

Your Benefit Summary

Open Option Plan

Clackamas County - General County Employees

PROVIDENCE Health Plan

Copay	What You Pay In-Plan	What You Pay Out-of-Plan	Calendar Year Common Out-of-Pocket Maximum (after deductible)	Calendar Year Common Deductible
$15	10% coinsurance (after deductible)	30% coinsurance (after deductible; UCR applies)	$2,000 per person $6,000 per family (3 or more)	$500 per person $1,500 per family (3 or more)

Important information about your plan

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

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

Open Option Plan Benefit Highlights ✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then you pay the following for covered services: In-Plan Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services		
• Office visits	$15 / visit✓	30%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	30%✓
• Vision and hearing screenings for children under 18	Covered in full✓	30%✓
• Routine immunizations; shots	Covered in full✓	30%✓
• Maternity services; pre- and postnatal visits	$150 / delivery✓	30%
• Allergy shots; serums; injectable medications	10%	30%
• Inpatient hospital visits	10%	30%
• Surgery; anesthesia	10%	30%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	30%✓
• Mammograms	Covered in full✓	30%
Hospital Services		
• Inpatient care	10%	30%
• Observation care	10%	30%
• Maternity care	10%	30%
• Routine newborn nursery care	10%✓	30%
• Rehabilitative care (30 days per calendar year)	10%	30%
• Skilled nursing facility (60 days per calendar year)	10%	30%
Outpatient Diagnostic Services		
• X-ray; lab services	10%✓	30%
• Imaging services (such as PET, CT, MRI)	10%✓	30%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year; deductible waived)	10%✓	30%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit✓	30%✓
• Emergency medical transportation	10%	10%

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services		
• Colonoscopy, sigmoidoscopy	Covered in full✓	30%
• Outpatient rehabilitative services (30 visits per calendar year)	10%	30%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	10%	30%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not Covered
• Home health care	10%	30%
• Hospice care	Covered in full✓	Covered in full✓
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓	Not covered
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	$10✓	Not covered
-Formulary brand-name drugs	$50✓	Not covered
-Non-formulary brand-name drugs	$100✓	Not covered
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	10%	30%
• Residential services	10%	30%
• Outpatient provider visits	$15 / visit✓	30%✓

Key terms and 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.

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Your Benefit Summary

Alternative Care Plan

Clackamas County - General County Employees on an Open Option Plan

PROVIDENCE Health Plan

Copay
$15

Maximum Calendar Year Benefit
$1,500 per member

Important information about your plan

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

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.
- With this benefit you have access to four of the most popular types of alternative health care providers: acupuncturists, chiropractors, massage therapists and naturopaths.

About your alternative care benefit

This plan covers alternative care services when they are:

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

What you need to know before you use this benefit

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

Using non-participating providers

- In rare circumstances, our national network may not have a participating provider in your area. If this occurs, please contact our authorizing agent at 1-800-678-9133. If our authorizing agent is not able to locate a participating provider within a reasonable distance, authorization for use of a non-participating provider will be provided.
- Non-participating providers must be licensed in the state in which they are practicing and must practice within the scope of their license.
- Payment to non-participating providers is based upon Usual, Customary, and Reasonable (UCR) charges. Amounts in excess of UCR are your responsibility.
- Claims should be submitted to American Specialty Health Network, 777 Front Street, San Diego, CA 92101.
- In some cases, you may need to pay the non-participating provider directly for the full cost of the services received and submit your itemized billing to our authorizing agent for reimbursement.
- You are responsible for obtaining prior authorization from our authorizing agent when receiving services from non-participating providers.

Acupuncture covered services

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

Chiropractic covered services

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

Naturopathy covered services

- Services must be provided within a course of treatment that includes both (a) natural treatment methods, modalities, nutritional advice, recommendation of homeopathic protocols, and (b) excludes prescribing prescription or over-the-counter drugs, surgery, or invasive therapeutic procedures.
- Office visits/consultations, therapeutic procedures and other services provided in various combinations.
- Physical therapy which may include ultrasound, hot packs, cold packs, manual, mechanical, or electrical stimulation of the muscles, rehabilitative exercise.
- Related diagnostic X-rays and laboratory services.
- All naturopathic services must be approved by Providence Health Plan or its authorizing agent as medically necessary.

Massage therapy covered services

- Short-term rehabilitative therapy.

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

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

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

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

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

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

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Your Benefit Summary

Hearing Aid

Clackamas County - General County Employees on an Open Option Plan

PROVIDENCE Health Plan

Benefits

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

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

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

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

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

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

Using your hearing aid benefits

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

- Please submit your itemized receipts suitable for insurance billing purposes to us for reimbursement.
  Submit claims to:
  Providence Health Plan
  Attn: Claims Dept.
  P.O. Box 3125
  Portland, OR 97208-3125

Exclusions

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

Your Benefit Summary

Out-of-Area Dependent

Clackamas County - General County Employees

PROVIDENCE Health Plan

What You Pay
20% coinsurance

Calendar Year Out-of-Pocket Maximum
$1,000 per person $3,000 per family (3 or more)

Important information about your plan

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

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

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

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

Your guide to the [illegible] used to explain your benefits

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

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

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

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

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

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

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

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

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

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

PROVIDENCE Health Plan

Important information about your plan

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

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copays, coinsurance and any difference in costs for prescription drugs do not apply to your calendar year medical plan out-of-pocket maximums, coinsurance maximums, or deductibles.

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

What you need to know about drug coverage categories

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

Using your prescription drug benefit

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

Using your prescription drug formulary

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

Ordering prescriptions by mail

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

If you use a non-participating pharmacy

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

What you need to know about limitations and exclusions

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

Limitations

- All drugs must be Food and Drug Administration (FDA) approved, medically necessary, and require by law, a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
- Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, they are not considered "maintenance" drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty medications are listed in the formulary.
- Self-injectible drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and referenced in the formulary.

Exclusions

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

Understanding the words or phrases used to describe your benefits

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

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

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

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

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

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only available after the brand-name patent expires. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about generic drugs.

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

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

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

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

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process is initiated by the prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit www.ProvidenceHealthPlan.com 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
Vision $400 Plan

PROVIDENCE Health Plan

Benefits

Your Providence Health Plan vision benefit provides coverage as follows:

- Adults: up to $400 per two calendar year period
- Children under 18: up to $400 per calendar year

You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your vision care benefit. The $400 coverage can be applied to the following services:

- Vision examinations
- Prescription lenses
- Prescription contact lenses
- Frames

Using your vision plan benefit

- For the service to be a covered benefit, you must receive all of your vision services and supplies care from a licensed eye care provider. Vision examinations must be provided by an ophthalmologist or an optometrist.
- Please submit your itemized receipts suitable for insurance billing purposes to us for reimbursement.
  Submit claims to:

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

Exclusions

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

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
Personal Option Plan
Clackamas County POA

PROVIDENCE Health Plan

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

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

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

Personal Option Plan Benefit Highlights	You pay the following for covered services: Copay or Coinsurance (from participating providers only)
Physician / Provider Services	
• Office visits	$15 / visit
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations; shots	Covered in full
• Maternity services; pre- and postnatal visits	$150 / delivery
• Allergy shots; serums; injectable medications	$15 / visit
• Inpatient hospital visits	Covered in full
• Surgery; anesthesia	Covered in full
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full
• Mammograms	Covered in full
Hospital Services	
• Inpatient care	Covered in full
• Observation care	Covered in full
• Maternity care	Covered in full
• Routine newborn nursery care	Covered in full
• Rehabilitative care (30 days per calendar year)	Covered in full
• Skilled nursing facility (60 days per calendar year)	Covered in full
Outpatient Diagnostic Services	
• X-ray; lab services	Covered in full
• Imaging services (such as PET, CT, MRI)	Covered in full
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$100
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit
• Emergency medical transportation	$50

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

Your guide to the words we use to explain your benefits

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

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

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

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

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

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

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

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Your Benefit Summary
Open Option Plan
Clackamas County POA

PROVIDENCE Health Plan

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

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

Open Option Plan Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.

	After you pay your calendar year common deductible, then you pay the following for covered services:	
	In-Plan Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services		
• Office visits	$10 / visit✓	20%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	20%✓
• Vision and hearing screenings for children under 18	Covered in full✓	20%✓
• Routine immunizations; shots	Covered in full✓	20%✓
• Maternity services; pre- and postnatal visits	$50 / delivery✓	20%
• Allergy shots; serums; injectable medications	Covered in full	20%
• Inpatient hospital visits	Covered in full	20%
• Surgery; anesthesia	Covered in full	20%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	20%✓
• Mammograms	Covered in full✓	20%
Hospital Services		
• Inpatient care	Covered in full	20%
• Observation care	Covered in full	20%
• Maternity care	Covered in full	20%
• Routine newborn nursery care	Covered in full✓	20%
• Rehabilitative care (30 days per calendar year)	Covered in full	20%
• Skilled nursing facility (60 days per calendar year)	Covered in full	20%
Outpatient Diagnostic Services		
• X-ray; lab services	Covered in full✓	20%
• Imaging services (such as PET, CT, MRI)	Covered in full✓	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year; deductible waived)	20%*	20%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$10 / visit✓	20%✓
• Emergency medical transportation	$50	$50

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

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

Your guide to the words or phrases used to explain 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.

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Your Benefit Summary
Out-of-Area Dependent
Clackamas County POA

PROVIDENCE Health Plan

What You Pay
20% coinsurance

Calendar Year Out-of-Pocket Maximum
$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.
- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- Some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

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

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

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

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

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

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

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

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

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

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

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

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

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www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary
Prescription Drug Plan
Clackamas County POA

PROVIDENCE Health Plan

Important information about your plan

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

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copays, coinsurance and any difference in costs for prescription drugs do not apply to your calendar year medical plan out-of-pocket maximums, coinsurance maximums, or deductibles.

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

What you need to know about drug coverage categories

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

Using your prescription drug benefit

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

Using your prescription drug formulary

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

Ordering prescriptions by mail

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

If you use a non-participating pharmacy

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

What you need to know about limitations and exclusions

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

Limitations

- All drugs must be Food and Drug Administration (FDA) approved, medically necessary, and require by law, a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
- Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, they are not considered "maintenance" drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty medications are listed in the formulary.
- Self-injectible drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and referenced in the formulary.

Exclusions

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

Understanding words or phrases used to explain your benefits

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

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

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

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

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

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only available after the brand-name patent expires. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about generic drugs.

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

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

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

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

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process is initiated by the prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit www.ProvidenceHealthPlan.com 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
Vision $200 Plan

PROVIDENCE Health Plan

Benefits

Your Providence Health Plan vision benefit provides coverage as follows:

- Adults: up to $200 per two calendar year period
- Children under 18: up to $200 per calendar year

You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your vision care benefit. The $200 coverage can be applied to the following services:

- Vision examinations
- Prescription lenses
- Prescription contact lenses
- Frames

Using your vision plan benefit

- For the service to be a covered benefit, you must receive all of your vision services and supplies care from a licensed eye care provider. Vision examinations must be provided by an ophthalmologist or an optometrist.
- Please submit your itemized receipts suitable for insurance billing purposes to us for reimbursement.
  Submit claims to:

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

Exclusions

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

Contact us
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Portland Metro Area: **503-574-7500**
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
Chiropractic Care Plan

PROVIDENCE Health Plan

Copay
$10

Maximum Calendar Year Benefit
$1,500 per member

Important information about your plan

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

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

About your chiropractic care benefit

This plan covers chiropractic care services when they are:

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

What you need to know before you use this benefit

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

Using non-participating providers

- In rare circumstances, our national network may not have a participating provider in your area. If this occurs, please contact our authorizing agent at 1-800-678-9133. If our authorizing agent is not able to locate a participating provider within a reasonable distance, authorization for use of a non-participating provider will be provided.
- Non-participating providers must be licensed in the state in which they are practicing and must practice within the scope of their license.
- In some cases, you may need to pay the non-participating provider directly for the full cost of the services received and submit your itemized billing to our authorizing agent for reimbursement.
- Claims should be submitted to American Specialty Health Network, 777 Front Street, San Diego, CA 92101.
- Payment to non-participating providers is based upon Usual, Customary, and Reasonable (UCR) charges. Amounts in excess of UCR are your responsibility.
- You are responsible for obtaining prior authorization from our authorizing agent when receiving services from non-participating providers.

What is covered

Benefits for outpatient chiropractic services include:

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

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

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

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

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

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

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

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Your Benefit Summary

Open Option Plan

Clackamas County - General County Early Retirees and COBRA Participants

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
$15	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$2,000 per person $6,000 per family (3 or more)	$1,000 per person $3,000 per family (3 or more)

Important information about your plan

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

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

Open Option Plan Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then you pay the following for covered services: In-Plan Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services		
• Office visits	$15 / visit✓	50%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	50%✓
• Vision and hearing screenings for children under 18	Covered in full✓	50%✓
• Routine immunizations; shots	Covered in full✓	50%✓
• Maternity services; pre- and postnatal visits	$100 / delivery✓	50%
• Allergy shots; serums; injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
Hospital Services		
• Inpatient care	30%	50%
• Observation care	30%	50%
• Maternity care	30%	50%
• Routine newborn nursery care	30%✓	50%
• Rehabilitative care (30 days per calendar year)	30%	50%
• Skilled nursing facility (60 days per calendar year)	30%	50%
Outpatient Diagnostic Services		
• X-ray; lab services	30%✓	50%
• Imaging services (such as PET, CT, MRI)	30%✓	50%
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)	30%*	50%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit✓	50%✓
• Emergency medical transportation	30%	30%

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

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services		
• Outpatient rehabilitative services (30 visits per calendar year)	30%	50%
• 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
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓	Not covered
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	$10✓	Not covered
-Formulary brand-name drugs	$50✓	Not covered
-Non-formulary brand-name drugs	$100✓	Not covered
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	30%	50%
• Residential services	30%	50%
• Outpatient provider visits	$15 / visit✓	50%✓

Your guide to the words or phrases used to describe 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.

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Your Benefit Summary

Open Option Plan

Clackamas County POA Early Retirees and COBRA Participants

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
$15	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$2,000 per person $6,000 per family (3 or more)	$1,000 per person $3,000 per family (3 or more)

Important information about your plan

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

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

Open Option Plan Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.

	After you pay your calendar year common deductible, then you pay the following for covered services:	
	In-Plan Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services		
• Office visits	$15 / visit✓	50%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	50%✓
• Vision and hearing screenings for children under 18	Covered in full✓	50%✓
• Routine immunizations; shots	Covered in full✓	50%✓
• Maternity services; pre- and postnatal visits	$100 / delivery✓	50%
• Allergy shots; serums; injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
Hospital Services		
• Inpatient care	30%	50%
• Observation care	30%	50%
• Maternity care	30%	50%
• Routine newborn nursery care	30%✓	50%
• Rehabilitative care (30 days per calendar year)	30%	50%
• Skilled nursing facility (60 days per calendar year)	30%	50%
Outpatient Diagnostic Services		
• X-ray; lab services	30%✓	50%
• Imaging services (such as PET, CT, MRI)	30%✓	50%
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)	30%*	50%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit✓	50%✓
• Emergency medical transportation	30%	30%

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

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

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.

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Your Benefit Summary

Non-Medicare Eligible Retired Employees

Clackamas County

PROVIDENCE Health Plan

Important information about your plan

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

Retired Employee definition

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

Retired Employee eligibility

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

Retired Employee dependent eligibility

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

Enrollment

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

Termination of coverage

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

Continuation of coverage

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

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www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary
Prescription Drug Plan

PROVIDENCE Health Plan

Important information about your plan

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

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copays, coinsurance and any difference in costs for prescription drugs do not apply to your calendar year medical plan out-of-pocket maximums, coinsurance maximums, or deductibles.

Drug Coverage Category	Copay or Coinsurance			Calendar Year Out-of-Pocket Maximum
	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)	
Generic drug	$10	$30	$10	**$1,000** per person **$3,000** per family (3 or more)
Brand-name drug	50%	50%	50%	
Compounded drug	50%	Does not apply	Does not apply	

What you need to know about drug coverage categories

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

Using your prescription drug benefit

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

Using your prescription drug formulary

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

Ordering prescriptions by mail

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

If you use a non-participating pharmacy

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

What you need to know about limitations and exclusions

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

Limitations

- All drugs must be Food and Drug Administration (FDA) approved, medically necessary, and require by law, a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
- Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, they are not considered "maintenance" drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty medications are listed in the formulary.
- Self-injectible drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and referenced in the formulary.

Exclusions

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

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

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

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

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

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

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

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only available after the brand-name patent expires. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about generic drugs.

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

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

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

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

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

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process is initiated by the prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit www.ProvidenceHealthPlan.com 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
Men's Elective Sterilization

PROVIDENCE Health Plan

Covered Services

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

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

For Members enrolled in a Health Savings Account (HSA) plan, the calendar year medical/pharmacy Deductible DOES apply to this benefit. Also, Copayments or Coinsurance payments for Services provided by this benefit apply to your calendar year medical/pharmacy Out-of-Pocket Maximum.

For Members on all other plans, the medical Deductible, if any, DOES NOT apply to this benefit, and Copayments or Coinsurance for Services provided by this benefit DO NOT apply to the calendar year Out-of-Pocket Maximums.

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

Please Note:

Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience Providence Health & Services facilities do not offer these services.

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

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

Domestic Partner Plus

Clackamas County

PROVIDENCE Health Plan

Important information about your plan

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

Domestic partner definition

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

Domestic partner means either of the following:

An Oregon Registered Domestic Partner is a person who is:

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

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

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

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

EXHIBIT D

Kaiser Permanente Medical Underwriting

KAISER PERMANENTE® KAISER FOUNDATION HEALTH PLAN, INC.

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional
Quote Name: Plan 13C–Custom subgroups 001, etc.

Region: Northwest
Contract Period: 01/01/2013 – 12/31/2013
Report Period: Mar 2011 through Feb 2012

	Mar11-Feb12
Average Members:	1,333
Rating Month:	March 2012
Rating Members:	1,157

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	Projected Claims Calculation					
A1	Paid Claims				$6,072,898	$379.746
A2	- Pooling Credit	Pooling Point:$160,000			(421,820)	(26.377)
A3	+ Pooling Charge				154,962	9.690
A4	Claims Net of Pooling				$5,806,040	$363.059
A5	X Incurred Claims Adjustment			1.01444		
A6	X Demographic Change			0.97908		
A7	X Historical Benefit Change			1.003180		
A8	Adjusted Claims					$361.743
A9	X Trend Factor	Annual Trend: 7.94%		1.15028		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$416.106
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem	PMPM$
D	Total Rate Calculation		$481,435	$416.106
D1	Blended Rate	1.000000		
D2	X Future Benefit Change		$481,435	$416.106
D3	Adjusted PMPM		37,313	32.250
D4	+ Retention		14,659	12.670
D5	+ Other Benefits		0	0.000
D6	+ Group Specific Charge		2,014	1.741
D7	+ Late Payment Charge		5,408	4.674
D8	+ Premium Tax		0	0.000
D9	+ Commission		$540,829	$467.441
D10	**Uncapped PMPM Premium Requirement**			
E	Capping	Increase		
E1	In-Force Rate		$505,391	$436.812
E2	Premium Requirement without Benefit Change and Underwriter Adj	7.01%	540,829	467.441
E3	Capping Rate	7.65%	544,054	470.228
E4	**Quoted Rate PMPM before Underwriter Adjustment**	**7.65%**	**544,054**	**470.228**
E5	X Underwriter Adjustment	1.00000		
E6	Quoted Rate PMPM after Underwriter Adjustment	7.65%	$544,054	470.228
E7	Capping Adjustment		3,225	2.787

Created On: 6/20/2012
NPS RQR Number: 5428660
External RQR ID: T16084R16453
NPS RQR Name: 2013 Clackamas Cty Renewal (mks)
NPS Quote id: 8778719

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KAISER PERMANENTE® KAISER FOUNDATION HEALTH PLAN, INC.

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional
Quote Name: Plan 13B-Custom subgroups 007, 018, 030

Region: Northwest
Contract Period: 01/01/2013 - 12/31/2013
Report Period: Mar 2011 through Feb 2012

	Mar11-Feb12
Average Members:	1,333

Rating Month: March 2012
Rating Members: 205

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	Projected Claims Calculation					
A1	Paid Claims				$6,072,598	$379.746
A2	- Pooling Credit	Pooling Point:$150,000			(421,820)	(26.377)
A3	+ Pooling Charge				154,962	9.690
A4	Claims Net of Pooling				$5,806,040	$363.059
A5	X Incurred Claims Adjustment			1.01444		
A6	X Demographic Change			0.97908		
A7	X Historical Benefit Change			1.000480		
A8	Adjusted Claims					$360.769
A9	X Trend Factor	Annual Trend: 7.94%		1.15028		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$414.986
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem	PMPM$
D	Total Rate Calculation			
D1	Blended Rate		$85,072	$414.986
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$85,072	$414.986
D4	+ Retention		6,611	32.250
D5	+ Other Benefits		2,435	11.880
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		355	1.734
D8	+ Premium Tax		954	4.655
D9	+ Commission		0	0.000
D10	Uncapped PMPM Premium Requirement		$95,429	$465.505
E	Capping	Increase		
E1	In-Force Rate		$85,343	$416.305
E2	Premium Requirement without Benefit Change and Underwriter Adj	11.82%	95,429	465.505
E3	Capping Rate	7.65%	91,871	448.152
E4	Quoted Rate PMPM before Underwriter Adjustment	7.65%	91,871	448.152
E5	X Underwriter Adjustment	1.00000		
E6	Quoted Rate PMPM after Underwriter Adjustment	7.65%	91,871	448.152
E7	Capping Adjustment		(3,557)	(17.353)

KAISER PERMANENTE® KAISER FOUNDATION HEALTH PLAN, INC.

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional-Low Deductible
Quote Name: Plan 1000 - Custom subgroups 058, 060

Region: Northwest
Contract Period: 01/01/2013 - 12/31/2013
Report Period: Mar 2011 through Feb 2012

	Mar11-Feb12
Average Members:	1,333

Rating Month: March 2012
Rating Members: 3

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	Projected Claims Calculation					
A1	Paid Claims				$6,072,898	$379.746
A2	- Pooling Credit	Pooling Point:$160,000			(421,820)	(26.377)
A3	+ Pooling Charge				154,962	9.690
A4	Claims Net of Pooling				$5,806,040	$363.059
A5	X Incurred Claims Adjustment			1.01444		
A6	X Demographic Change			0.97908		
A7	X Historical Benefit Change			0.754530		
A8	Adjusted Claims					$272.079
A9	X Trend Factor	Annual Trend: 7.94%		1.15028		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$312.967
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	Total Rate Calculation			
D1	Blended Rate		$939	$312.967
D2	X Future Benefit Change	1.008090		
D3	Adjusted PMPM		$946	$315.498
D4	+ Retention		97	32.250
D5	+ Other Benefits		36	11.880
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		4	1.358
D8	+ Premium Tax		11	3.646
D9	+ Commission		0	0.000
D10	**Uncapped PMPM Premium Requirement**		$1,094	$364.632
E	Capping	increase		
E1	In-Force Rate		$1,217	$405.540
E2	Premium Requirement without Benefit Change and Underwriter Adj	(10.71)%	1,086	362.101
E3	Capping Rate	7.65%	1,310	436.564
E4	**Quoted Rate PMPM before Underwriter Adjustment**	8.42%	1,319	439.697
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	8.42%	1,319	439.697
E7	Capping Adjustment		223	74.463

Created On: 6/20/2012
NPS RQR Number: 5428660

External RQR ID: T16084R16453
NPS RQR Name: 2013 Clackamas Cty Renewal (mks)

NPS Quote id: 8778725

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KAISER PERMANENTE® KAISER FOUNDATION HEALTH PLAN, INC.

Rate Buildup

Group Name: CLACKAMAS COUNTY
Group Number(s): 1183
Subgroup(s): 001 ,007 ,013 ,018 ,024 ,028 ,029 , 030 ,031 ,032 ,040 ,042 ,058 ,059
Product Type: Traditional-Low Deductible
Quote Name: Plan 1000 - Custom subgroups 059, 063

Region: Northwest
Contract Period: 01/01/2013 - 12/31/2013
Report Period: Mar 2011 through Feb 2012

	Mar11-Feb12
Average Members:	1,333

Rating Month: March 2012
Rating Members: 12

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	Projected Claims Calculation					
A1	Paid Claims				$6,072,698	$379.746
A2	- Pooling Credit	Pooling Point: $160,000			(421,820)	(26.377)
A3	+ Pooling Charge				154,962	9.690
A4	Claims Net of Pooling				$5,806,040	$363.059
A5	X Incurred Claims Adjustment			1.01444		
A6	X Demographic Change			0.97908		
A7	X Historical Benefit Change			0.756560		
A8	Adjusted Claims					$272.814
A9	X Trend Factor	Annual Trend: 7.94%		1.15028		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$313.812
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	Total Rate Calculation		$3,766	$313.812
D1	Blended Rate	1.008090		
D2	X Future Benefit Change		$3,796	$316.349
D3	Adjusted PMPM		387	32.250
D4	+ Reretion		133	11.880
D5	+ Other Benefits		0	0.000
D6	+ Group Specific Charge		16	1.361
D7	+ Late Payment Charge		44	3.655
D8	+ Premium Tax		0	0.000
D9	+ Commission		$4,386	$365.495
D10	**Uncapped PMPM Premium Requirement**			
E	Capping	Increase		
E1	In-Force Rate		$4,461	$371.731
E2	Premium Requirement without Benefit Change and Underwriter Adj	(2.36)%	4,355	362.958
E3	Capping Rate	7.65%	4,802	400.168
E4	**Quoted Rate PMPM before Underwriter Adjustment**	8.41%	4,836	403.006
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	8.41%	4,836	403.006
E7	Capping Adjustment		447	37.210

EXHIBIT E

Kaiser Permanente 2013 Contract Changes

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2013 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," riders, and any applicable endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement* and any changes we have made at your Group's request. Additional administrative changes may occur throughout the remainder of the year. Other Group-specific or product-specific plan design changes may apply, such as moving to standard benefits. Refer to the benefits shown on the rate and benefit summary pages in the Group's renewal packet for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2013. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

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

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

Benefit changes

- The "Limited Outpatient Prescription Drugs, Supplies, and Supplements" *EOC* section has been modified. The medical plan now includes a cost share for outpatient administered medications. This change is also reflected on the *EOC* "Benefit Summary" under "Outpatient Services." This change brings our plans into better alignment with the industry.
- For Traditional Plans, Coinsurance for covered Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices now counts toward the Out-of-Pocket Maximum. For Added Choice Plans, this change applies to the Tier 1 benefit. Previously, Outpatient DME, External Prosthetic Devices, and Orthotic Devices counted toward the Out-of-Pocket Maximum in Tier 2 and Tier 3 only. This change brings our plans into better alignment with the industry and provides catastrophic out-of-pocket protection to our Members.
- For Deductible Plans, Coinsurance for covered Outpatient DME, External Prosthetic Devices, and Orthotic Devices now counts toward the Deductible and Out-of-Pocket Maximum. For Deductible Added Choice Plans, this change applies to the Tier 1 benefit. Previously, Outpatient DME, External Prosthetic Devices, and Orthotic Devices counted toward the Deductible and Out-of-Pocket Maximum in Tier 2 and Tier 3 only. This change brings our plans into better alignment with the industry and provides catastrophic out-of-pocket protection to our Members.
- Coinsurance for Ambulance Services now counts toward the Deductible and Out-of-Pocket Maximum for Deductible Plans. For Deductible Added Choice Plans, this change applies to Tier 1. Previously, Ambulance Services counted toward the Deductible and Out-of-Pocket Maximum in Tier 2 and Tier 3 only. This change brings our plans into better alignment with the industry and provides catastrophic out-of-pocket protection to our Members.

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- Special diagnostic procedures (CT, MRI, and PET scans) are now subject to an increased Copayment. The change is reflected under "Outpatient Laboratory, X-rays, Imaging, and Special Diagnostic Procedures" in the *EOC* "Benefit Summary." This applies to Traditional Plans, Deductible Plans, and Added Choice Plans in Tier 1 and brings these plans into better alignment with the industry.
- The dollar allowance explanation for the state-mandated hearing aid benefit for Members under age 18 and any child Dependents has been modified in the "Hearing Services" *EOC* section. The statement that the dollar allowance can be used only at the initial point of sale has been deleted.
- The hearing aid annual allowance for the state-mandated hearing aid benefit for Members under age 18 and any child Dependents has been increased based on the Consumer Price Index for medical care. This change is reflected on the *EOC* "Benefit Summary" under "Hearing Services."
- Specialty care visits are now subject to a Copayment that is $10 higher than primary care visits on Traditional Plans as shown on the *EOC* "Benefit Summary." This change brings the plans into better alignment with the industry.
- The "Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices" *EOC* section has been modified. In the bullet describing coverage for external prostheses after a Medically Necessary mastectomy, coverage has increased from three brassieres required to hold a prosthesis to four brassieres every 12 months. Also, explanation has been added that external prostheses are subject to a frequency limitation of 24 months.
- The "Mental Health Services Exclusions and Limitations" *EOC* section has been modified. We no longer exclude mental health Services for gender-identity disorders in adults.
- Effective August 1, 2012, medical plans that include the Affordable Care Act (ACA) preventive care Services coverage with no Member cost share also cover women's preventive care Services specified in the Health Resources and Services Administration (HRSA) guidelines at no charge, not subject to any Deductible. Certain religious employer groups may be exempt from providing contraceptive coverage.

Benefit clarifications

- The definition of Out-of-Pocket Maximum in the "Definitions" *EOC* section has been modified. We have reworded the definition to reference Copayments and Coinsurance, instead of Charges, for clarification.
- The "Definitions" *EOC* section has been modified to align with provider and facility references in our *Medical Directory*.
- Several *EOC* sections have been updated to clarify the referral and prior authorization requirements for specialty Services and for Services from Non-Participating Providers and Non-Participating Facilities.
- The "Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics" *EOC* section has been modified. We have clarified that we cover standard glucose blood monitors, but not continuous-type monitoring devices.
- Exclusions have been clarified to explain we do not cover Services provided by unlicensed people, or items and Services that are not health care items or health care Services.
- The exclusion for Dental Services has been modified. We have added language clarifying that coverage for Medically Necessary general anesthesia in conjunction with non-covered dental Services is subject to Utilization Review.

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- The Experimental or Investigational Services exclusion has been modified. We have clarified that we cover routine care for Members enrolled in and participating in qualifying clinical trials if such care would have been covered by Company under this *EOC* absent a clinical trial.

Administrative changes or clarifications

- The "Reporting Membership Changes and Retroactivity" provision under the "Miscellaneous Provisions" section of the *Group Agreement* has been modified. We have clarified that membership forms must be approved by Company.
- The definition of "Dependent Limiting Age" has been clarified to explain that Spouses are not subject to the Dependent Limiting Age.
- The "Termination Due to Loss of Eligibility" *EOC* section has been modified in the Traditional, Deductible, and High Deductible *EOCs* only. We have deleted the text that stated we terminate the memberships of COBRA Members who permanently reside outside our Service Area and do not work for any employer at least 50 percent of the time within our Service Area. The text did not reflect administrative practices, as COBRA coverage is not terminated for Members who reside outside of our Service Area.
- The "State Continuation Coverage for Non-COBRA Groups" *EOC* section has been modified to comply with state law. A description of qualifying events and how to request continuation coverage under this provision has been added.
- The "HIPAA and Other Individual Plans" provision in the "Conversion to an Individual Plan" *EOC* section has been removed. The provision is redundant, as the eligibility requirements for portability coverage are described in the "Portability Plans" section.
- The "Miscellaneous Provisions" *EOC* section has been modified. We have added a new "Annual Summaries and Additional Information" provision that describes information Members can request from the Oregon Department of Consumer and Business Services.
- The "Claims Review Authority" paragraph in the "Miscellaneous Provisions" *EOC* section has been deleted. The text did not reflect our administrative practices.

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

Benefit changes

- The definition of "Usual and Customary Fee" in the *EOC* "Definitions" section has been changed to "Allowed Amount." The definition applies to Tier 3 only. Allowed Amount is based on billed Charges or 160 percent of the Medicare rate, whichever is lower.
- The "Services Subject to Permanente Advantage Prior Authorization Review under Tier 2 and Tier 3" and "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" *EOC* sections have been modified. Bone density/DXA scans covered under Tier 2 or Tier 3 now require prior authorization by Permanente Advantage.

Benefit clarifications

- The "When Referrals are Required under Tier 2 and Tier 3" *EOC* section has been clarified. Provider referrals are not limited to physician referrals.

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- The *EOC* has been modified to clarify that we have the right to determine medical necessity.
- Several sections of the *EOC* have been modified to clarify that when a Select Physician refers a Member to any hospital or other facility, that hospital or facility is covered under the Tier 1 benefit.
- The "Post-Stabilization Care" *EOC* provision has been modified. We have clarified that if the Member is clinically stable and declines special transportation to a Select Provider or Select Facility (or other designated provider or facility), Post-Stabilization Care Services will be covered under Tier 2 (for Services provided by a PPO Facility or a PPO Provider) or Tier 3 (for Services provided by a Non-Participating Facility or a Non-Participating Provider).

Administrative changes or clarifications

- The term "Allied Health Professional" has been removed from the "Definitions" *EOC* section because the term is not used elsewhere in the document.
- The "What You Pay" *EOC* section has been modified to include consistent language when describing deductible carry-over and deductible take-over provisions. The definition of Deductible in the "Definitions" *EOC* section has also been updated for consistency.

Changes and clarifications that apply to medical benefit riders

Benefit changes

- The "Outpatient Prescription Drug Riders" have been changed in accordance with the Affordable Care Act. We have eliminated Copayments and Coinsurance for FDA-approved contraceptive drugs and devices included on our drug formulary.
- The "Outpatient Prescription Drug Rider" available with Traditional, Deductible, and High Deductible Health Plans that includes a higher cost share for Approved Non-Formulary Drugs has been modified. We have decreased the Member cost share for Approved Non-Formulary Generic Drugs. The Member pays the Generic Drug cost share for both the Generic Formulary and Generic Approved Non-Formulary Drug.
- The dollar allowance explanation for vision hardware and adult hearing aids has been changed in the respective "Vision Hardware and Optical Services Rider" and "Hearing Aid Rider." The statement that the dollar allowance can be used only at the initial point of sale has been deleted.
- Language has been changed in certain "Vision Hardware and Optical Services Riders." The provision that allowed for replacement eyeglass lenses or contact lenses within 12 months was erroneous for 12-month benefit allowance plans. The provision is applicable only to "Vision Hardware and Optical Services Riders" with a 24-month benefit allowance period.

Benefit clarifications

- The "Outpatient Prescription Drug Rider Benefit Summary" Mail Delivery Pharmacy rows have been removed. The information has been incorporated into the Participating Pharmacy rows since the Member cost share for drugs, supplies, or supplements obtained from a Participating Pharmacy and from a Mail Delivery Pharmacy are the same. Note this change does not apply to maintenance drugs.
- The Added Choice "Outpatient Prescription Drug Rider" that covers Brand-Name and Generic Drugs only if obtained at Select Pharmacies has been modified. The definitions of "Preferred Brand-Name Drug" and "Non-Preferred Brand-Name Drug" have been deleted because the terms are not used elsewhere in the rider.

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- The Added Choice "Outpatient Prescription Drug Rider" that includes the MedImpact pharmacy network option has been modified. The definition of "Approved Non-Formulary Brand-Name or Generic Drug" has been added. Cost-share tiers are now included in the "Outpatient Prescription Drug Rider Benefit Summary" for "Formulary Brand-Name Drugs" and "Approved Non-Formulary Brand-Name Drugs." These cost-share tiers apply to drugs obtained from Select pharmacies.
- The "Hearing Aid Rider" has been modified. We have added a bullet under the "Hearing Aid Exclusions" section to clarify that cleaners, moisture guards, and assistive listening devices are not covered.
- The "Vision Hardware and Optical Services Rider" has been modified. We have clarified that nonprescription lenses and contacts, including sunglasses, are not covered.

Changes and clarifications that apply to dental plans

Benefit changes

- In the Dental Choice PPO Plan, the "Limitations" *EOC* section has been modified. The age limit for sealant coverage has been increased to persons aged 15 years. Previously, the limit applied to persons aged 14 years.

Benefit clarifications

- In the Dental Choice PPO Plan, the "Benefits," "Exclusions," and "Limitations" *EOC* sections have been updated for clarification and standardization.
- In the Dental Choice PPO Plan, the "DenteMax" definition has been deleted and "Participating Provider" definition has been revised. Dental Choice Participating Providers are not limited to DenteMax providers.
- In the Dental Choice PPO Plan, the "Prior Authorization" *EOC* section has been modified. We have clarified our prior authorization procedures.
- An exclusion has been added in the "Exclusions and Limitations" *EOC* section to clarify that fees a provider may charge for Emergency Dental Care or Urgent Dental Care visits are not covered. These provider fees are not Copayments or Coinsurance for covered Services.
- In the Dental Deductible Plan, Emergency Dental Care Services have been clarified in the *EOC* "Benefit Summary." The Member pays Copayments or Coinsurance that normally apply to non-emergency dental care Services. The fee for Emergency or Urgent Dental Care visits has been deleted, since provider fees are not Copayments or Coinsurance for covered Services.

Administrative changes or clarifications

- The "Reporting Membership Changes and Retroactivity" provision under the "Miscellaneous Provisions" section of the *Group Agreement* has been modified. We have clarified that membership forms must be approved by Company.
- The definition of "Dependent Limiting Age" has been clarified to explain that Spouses are not subject to the Dependent Limiting Age.
- The "Grievances, Claims, and Appeals" *EOC* section is updated to provide a more detailed and accurate description of the grievances and appeals process.
- In the Deductible Dental Plan, the "Termination Due to Loss of Eligibility" *EOC* section has been modified. We have deleted the text that stated we terminate the memberships of COBRA Members who

KAISER PERMANENTE

permanently reside outside our Service Area and do not work for any employer at least 50 percent of the time within our Service Area. The text did not reflect administrative practices, as COBRA coverage is not terminated for Members who reside outside of our Service Area.

- The "Claims Review Authority" paragraph in the "Miscellaneous Provisions" *EOC* section has been deleted. The text did not reflect our administrative practices.

Changes and clarifications that apply to all Senior Advantage plans

The following changes take effect as Groups renew in 2013 unless otherwise noted.

These preliminary changes and clarifications do not include changes that may occur throughout the remainder of the year, including, but not limited to, mandated federal and state changes.

Benefit changes or clarifications

- Additional preventive services have been added to the CMS, zero cost-share list. Additional preventive CMS services may be added to the list throughout the 2013 plan year. All Medicare-covered preventive services will continue to be provided at no cost.

Administrative changes or clarifications

- The "Medicare Eligible and Members Age 65 or Over" provision in the medical *Group Agreement* has been modified. Text has been added to more fully explain when Medicare is primary or secondary payor for domestic partners of actively working Subscribers.
- The "Reporting Membership Changes and Retroactivity" provision in the "Miscellaneous Provisions" section has been deleted from the *Group Agreement*. This provision is not applicable to Senior Advantage.
- The "Medicare Eligible and Members Age 65 or Over" provision in the medical *Group Agreement* has been modified to eliminate the higher premium applied for Medicare primary members who are Medicare eligible due to disability and ESRD when they do not enroll in the group Senior Advantage plan. Non-Medicare (commercial) rates will apply.
- The "Medicare Eligible and Members Age 65 or Older" provision in the medical *Group Agreement* has been modified to eliminate the higher premium applied for Medicare primary members who enroll in the group COBRA plan and do not enroll in the group Senior Advantage plan. Non-Medicare (commercial) rates will apply.

EXHIBIT F

Kaiser Permanente Benefit Summaries

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

Summary of medical benefits

Clackamas County 1183-001, 013, 024, 028, 029, 031, 032, 040
Oregon Traditional Plan C13C
January 1, 2013 through December 31, 2013

Out-of-Pocket Maximum (Not all services apply to the maximum.)	
For one Member	$600 per Calendar Year
For an entire Family	$1,200 per Calendar Year
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$10
Specialty care visit	$10
Urgent care visit	$10
Emergency department visit	$75 (Waived if admitted)
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Laboratory, X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Administered medications (all outpatient settings)	$0
Routine eye exam	$10
Injection visit provided in nurse treatment area	$0
Durable medical equipment, external prosthetic devices, and orthotic devices	$0
Physical, speech, and occupational therapies (up to 20 visits per Calendar Year)	$10
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	$10
Inpatient Hospital Services	$0
Ambulance Services (per transport)	$75
Hearing Aids for Children (up to $4,367 every 48 months, per Member under age 18 and any child Dependent)	$0
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	$0
Optional Benefits	
Alternative care (self-referred)	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing aids (for Members age 18 and over)	Balance after $1500 allowance is applied for each hearing aid per ear every three years
Outpatient prescription drugs	$10 generic/$20 brand up to 30-day supply; up to 90-day supply of maintenance drugs for two Copayments when you use mail delivery.
Vision hardware and optical Services	Balance after $250 allowance every 24 months
Travel Services	Not covered

Chemical Dependency Services	
Outpatient Services	$10
Inpatient hospital & residential Services	$0
Mental Health Services	
Outpatient Services	$10
Inpatient hospital & residential Services	$0

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Language Interpretation Services, all areas..1-800-324-8010

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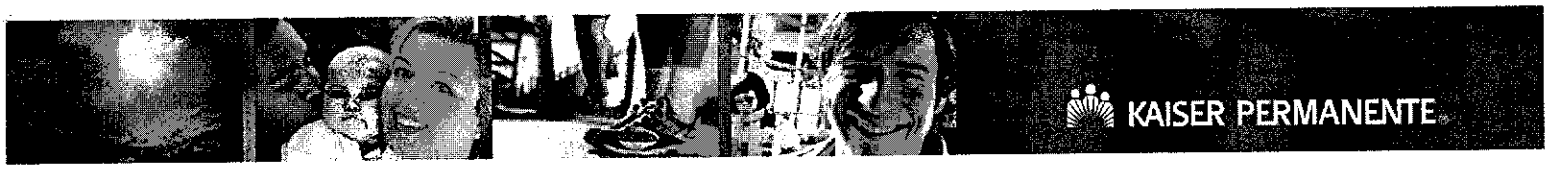

All plans offered and underwritten by Kaiser Foundation Health Plan
of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

Clackamas County 1183-007, 018, 030
Oregon Traditional Plan C13B
January 1, 2013 through December 31, 2013

Out-of-Pocket Maximum (Not all services apply to the maximum.)	
For one Member	$600 per Calendar Year
For an entire Family	$1,200 per Calendar Year
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$10
Specialty care visit	$10
Urgent care visit	$10
Emergency department visit	$75 (Waived if admitted)
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Laboratory, X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Administered medications (all outpatient settings)	$0
Routine eye exam	$10
Injection visit provided in nurse treatment area	$0
Durable medical equipment, external prosthetic devices, and orthotic devices	$0
Physical, speech, and occupational therapies (up to 20 visits per Calendar Year)	$10
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	$10
Inpatient Hospital Services	$0
Ambulance Services (per transport)	$75
Hearing Aids for Children (up to $4,367 every 48 months, per Member under age 18 and any child Dependent)	$0
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	$0
Optional Benefits	
Alternative care (self-referred)	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing aids (for Members age 18 and over)	Not covered
Outpatient prescription drugs	$10 generic/$20 brand up to 30-day supply; up to 90-day supply of maintenance drugs for two Copayments when you use mail delivery.
Vision hardware and optical Services	Balance after $200 allowance every 24 months
Travel Services	Not covered
Chemical Dependency Services	

Outpatient Services	$10
Inpatient hospital & residential Services	$0
Mental Health Services	
Outpatient Services	$10
Inpatient hospital & residential Services	$0

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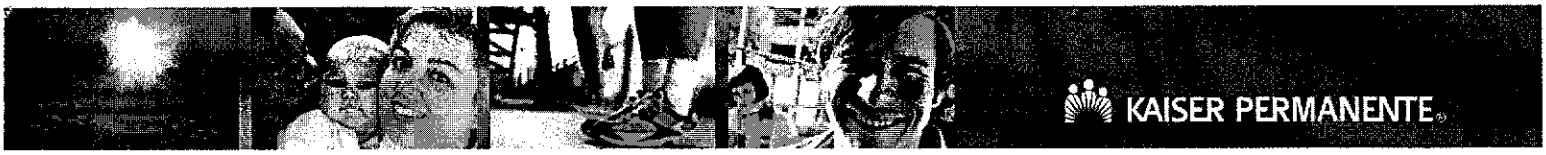

All plans offered and underwritten by Kaiser Foundation Health Plan
of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

Clackamas County 1183-059, 063
Oregon Deductible Plan 3C13
January 1, 2013 through December 31, 2013

Deductible	
For one Member	$1,000 per Calendar Year
For an entire Family	$3,000 per Calendar Year
Out-of-Pocket Maximum (Not all services apply to the maximum. Deductible amounts and Services not subject to the Deductible do not count toward your Out-of-Pocket Maximum.)	
For one Member	$3,000 per Calendar Year
For an entire Family	$9,000 per Calendar Year
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$25
Specialty care visit	20% Coinsurance after Deductible
Urgent care visit	$25
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Laboratory, X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0
Administered medications (all outpatient settings)	$0
Routine eye exam	$25
Injection visit provided in nurse treatment area	$5
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per Calendar Year)	20% Coinsurance after Deductible
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Ambulance Services (per transport)	20% Coinsurance after Deductible
Hearing Aids for Children (up to $4,367 every 48 months, per Member under age 18 and any child Dependent)	20% Coinsurance after Deductible
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Optional Benefits	
Alternative care (self-referred)	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing aids (for Members age 18 and over)	Balance after $1500 allowance is applied for each hearing aid per ear every three years

Outpatient prescription drugs	$15 generic/$30 brand up to 30-day supply; up to a 90-day supply of maintenance drugs for two Copayments when you use mail delivery.
Vision hardware and optical Services	Balance after $200 allowance every 24 months
Travel Services	Not covered
Chemical Dependency Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible

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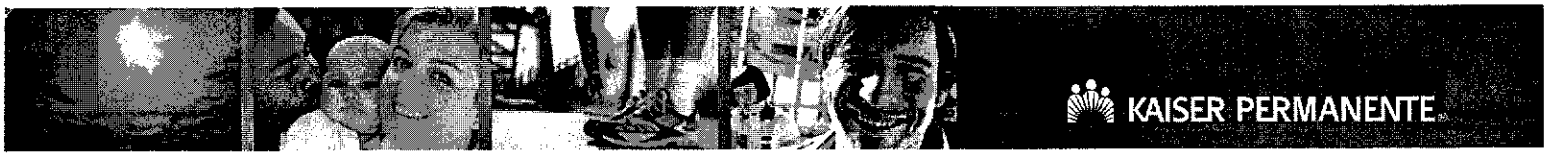

All plans offered and underwritten by Kaiser Foundation Health Plan
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Summary of medical benefits

Clackamas County 1183-058, 060
Oregon Deductible Plan 3C13
January 1, 2013 through December 31, 2013

Deductible	
For one Member	$1,000 per Calendar Year
For an entire Family	$3,000 per Calendar Year
Out-of-Pocket Maximum (Not all services apply to the maximum. Deductible amounts and Services not subject to the Deductible do not count toward your Out-of-Pocket Maximum.)	
For one Member	$3,000 per Calendar Year
For an entire Family	$9,000 per Calendar Year
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$25
Specialty care visit	20% Coinsurance after Deductible
Urgent care visit	$25
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Laboratory, X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	$0
Administered medications (all outpatient settings)	$0
Routine eye exam	$25
Injection visit provided in nurse treatment area	$5
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per Calendar Year)	20% Coinsurance after Deductible
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Hearing aids (for Members age 18 and over)	Not covered
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Vision hardware and optical Services	Balance after $200 allowance every 24 months
Travel Services	Not covered
Chemical Dependency Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible

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Summary of dental benefits

Clackamas County 1183-043, 045-047, 049-055
Oregon Dental Plan C
January 1, 2013 through December 31, 2013

Benefit Maximum	None
	You Pay
Dental Office Visit Charge – Applies to all visits	$5
Deductible (applies to all services unless otherwise indicated)	
For one Member	$0
For an entire Family	$0
Preventive and Diagnostic Services (oral exam, x-rays, teeth cleaning, fluoride) (Not subject to the Deductible)	No additional charge
Basic Restoration Services (routine fillings, plastic and steel crowns, simple extractions)	No additional charge
Oral Surgery Services (surgical tooth extractions)	No additional charge
Periodontics (treatment of gum disease, scaling and root planing)	No additional charge
Endodontics (root canal therapy)	No additional charge
Major Restoration Services (gold or porcelain crowns, bridges)	$45 for each
Removable Prosthetic Services	
Full and partial dentures	$95 for each partial denture, $65 for each full denture
Relines	$25
Rebases	$25
Emergency Dental Care	
From Participating Providers	Copayments or Coinsurance that normally apply for non-emergency dental care Services.
From Non-Participating Providers outside the Service Area	All Charges over $100
Nitrous oxide	
Adults and children age 13 years and older	$15
Children age 12 years and younger	$0
Orthodontics	Members age 17 years and younger: 50% of Charges up to Lifetime Benefit Maximum of $2,000, and 100% of Charges thereafter. Members age 18 years and older: 50% of Charges up to Lifetime Benefit Maximum of $2,000, and 100% of Charges thereafter.

Exclusions

- Conditions for which Service or reimbursement is required by law to be provided at or by a government agency.
- Cosmetic Services.
- Dental implants unless coverage for dental implants as an additional benefit has been purchased.
- Experimental or investigational treatments.

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

Limitations

- Repair or replacement due to normal wear of fixed and removable prosthetic devices that are less than five years old.
- Sedation and general anesthesia are not covered, except when administered pursuant to the Nitrous Oxide benefit as described in the "Other Benefits" section of your EOC.
- Works-in-Progress started prior to effective date of coverage.

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

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

EXHIBIT G

ODS 2013 Contract Changes

Clackamas County 10000174

ASO Dental Plan Changes
Effective January 1, 2013

The following is a summary of the significant changes that will be made to the ODS member handbook effective January 1, 2013. The summary is provided for your convenience and shall not be binding upon the parties. The language in the member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic, or formatting changes, are not included in this summary.

BENEFIT CHANGES

Accepted		Reference	Change/Rationale/Exceptions	Former Benefit	Claims Impact
Yes	No				
☐	☐	Benefits and Limitations	ViziLite Plus TBlue is no longer a covered benefit. With more recent evidence-based results, the initial findings of the effectiveness of ViziLite Plus TBlue turn out to be inconclusive.	ViziLite Plus TBlue was covered twice in a calendar year.	-0.06%
☐	☐	Exclusions	Services provided under separate contracts from the Group (e.g. medical and dental) are considered parts of the same plan. Clarification that if a service is covered under the member's medical plan, then the dental plan will not cover the procedure, except for accident related dental claims.	Benefits under separate contracts under the Group for covered persons were coordinated.	negligible

ADMINISTRATIVE CHANGES

Reference	Change/Rationale/Exceptions
Throughout handbook	Continued language simplification and cleanup
Throughout handbook	Deleted specific references for federal regulations
General Plan Information	Removed the General Plan Information section.
Dental Benefits and Limitations	Added a new section for anesthesia services. Clarification.
Exclusions	Revision of Exclusion section. No benefit changes.
Exclusions	Added an exclusion for "never events" for events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth are excluded. Clarification on plan exclusions to describe current internal policies.
Exclusions	Revised Service, War or Insurrection, Riot or Rebellion exclusion to include illegal acts.
Eligibility	Added spouses or domestic partners who are both eligible may each enroll as a subscriber or one may be covered as an enrolled dependent of the other. Clarification.
Eligibility	Clarification that ODS requires continuous coverage to cover disabled dependents beyond the age of 26.
Continuation of Coverage	Changed Plan Administrator to COBRA Administrator and qualified beneficiary to member. Clarification.
Continuation of Coverage	Deleted ARRA as it no longer applies.

EXHIBIT H

ODS Benefit Summaries

Dental Benefits Summary
Clackamas County
Preventive Dental Plan
Effective January 1, 2013

How To Use this Dental Plan

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

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

* **Deductible waived for preventive services.**

Advantages

DELTA DENTAL

* **Freedom to choose your dentist** As the Delta Dental Plan, members have the option of choosing a Delta Dental Plan that provides access to over 100,000 dental professionals nationwide. ODS is unique in that we have contracts with over 1,800 licensed dentists in Oregon.

* **Professional Arrangements** ODS has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS and our Delta Dental affiliates. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.

* **myODS** is a customized member website with current, accurate and easy to understand information about the member's plan. Log onto www.odscompanies.com/members to access myODS.

Dependent Eligibility

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

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

Visit our website at www.odscompanies.com

This product is underwritten or administered
by Oregon Dental Service

LIMITATIONS

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

Preventive

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

Basic

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

Major

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

EXCLUSIONS

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

Visit our website at www.odscompanies.com

Dental Benefits Summary
Clackamas County
Incentive Dental Plan
Effective January 1, 2013

How To Use this Dental Plan

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

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

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

** See your member handbook for specific orthodontic benefits.

Advantages

DELTA DENTAL

- **Freedom to choose your dentist** ODS is unique in that we have contracts with over 1,800 licensed dentists in Oregon. As the Delta Dental Plan of Oregon, we offer access to over 100,000 dental professionals nationwide.
- **Professional Arrangements** ODS has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS and our Delta Dental affiliates. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
- **myODS is** a customized member website with current, accurate and easy to understand information about the member's plan. Log onto www.odscompanies.com/members to access myODS.

Dependent Eligibility

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

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

Visit our website at www.odscompanies.com

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by Oregon Dental Service

LIMITATIONS

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

Preventive (Class I Services)

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

Basic (Class II Services)

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

Major (Class III Services)

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

EXCLUSIONS

* Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
* Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
* Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
* Services started prior to the date the individual became eligible for services under the program.
* Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric
* 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.

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Dental Benefits Summary
Clackamas County
Constant Dental Plan
Effective January 1, 2013

How To Use this Dental Plan

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

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* Missed or broken appointments.
* Precision attachments.
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* Orthodontic services.
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EXHIBIT I

Self-funded Dental Plan Underwriting Calculation

Clackamas County

General County ODS Dental Plan Renewal Calculation

Effective: January 1, 2013

Experience Period: July 1, 2011 through June 30, 2012

Line No.		ODS Dental
	Base Period Experience	
1.	Average Monthly Enrollment	1,478
2.	Billed Premium	$2,259,625
3.	Paid Claims	2,140,209
	Basic Assumptions	
4.	Annual Trend	6.0%
5.	Reserve Factor	10.0%
6.	Margin	0.0%
	Premium (Includes ee contrib)	
7.	Adjusted Premium to 2012 Rates	$2,278,765
	Claims	
8.	Paid Claims: 7/11 through 6/12	$2,140,209
9.	Claims Adjustment for Benefit changes	0
10.	Adjusted Paid Claims	$2,140,209
11.	Beginning Reserve	(197,820)
12.	Ending Reserve	214,021
13.	Reserve Change	$16,201
14.	Incurred Claims: 7/11 through 6/12	$2,156,410
	Projection	
15.	Annual Trend Factor	6.0%
16.	Extended Trend Factor for 18 mos.	1.091
17.	Projected Incurred Claims	$2,352,643
18.	Projected Incurred Loss Ratio	103.2%
19.	Margin	0.0%
20.	Projected Incurred Claims with Margin	$2,352,643
21.	Projected Incurred Loss Ratio with Margin	103.2%
	Expenses	
22.	Projected Renewal Administration expenses	
23.	Retention Net of Commission ($6.02 PEPM)	$106,801
24.	**Total Expenses**	$106,801
25.	Total Projected Outgo (Claims + Expenses)	$2,459,444
26.	**Needed Increase**	**7.9%**
27.	**Total Cost (PEPM)**	**$138.63**

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